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SCOTTISH HEALTH SERVICES COUNCIL

# FORENSIC PSYCHIATRY

*Report of a Sub-Committee  
of the Standing Medical Advisory  
Committee*



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# FORENSIC PSYCHIATRY

## CHAPTER I

### Introduction

1. We were appointed by the Standing Medical Advisory Committee on 27th February 1964 with the following terms of reference:

“To consider the provision and development of psychiatric services required: to furnish the courts with the assistance requested by them in deciding the disposal of offenders; to assist other services responsible for the treatment of such persons; and to treat persons referred by those services or by the courts”.

2. We have held 23 meetings, and made visits to the Home Office, State Hospital and certain approved schools and penal institutions in Scotland and England. Evidence has been taken from the individuals and organisations listed in Appendix A.

3. From the information gained in these various ways we have made our recommendations with particular reference to those psychiatric and allied services which could be provided under the National Health Service (Scotland) Act 1947.

4. The question which is basic to the whole subject matter of this Report is: “What is the potential contribution of the psychiatrist and psychiatric services to the treatment of offenders?” An answer is sought in Chapter II, as a prelude to the descriptions and recommendations of the ensuing chapters.

5. Each year many thousands of persons are dealt with by the Scottish courts. Provided a plea of guilty is tendered, and the charge is not regarded as too serious, the majority of cases (e.g. most of those brought under the Road Traffic Acts) are disposed of without the offender being required to appear before the court. In these circumstances the court finds itself able to decide on matters such as sentence without either seeing the offender or having detailed enquiries made about his personal characteristics. In other circumstances, however, the court has the offender appear before it in person, and in a minority of these cases is supplied with very detailed information about him before coming to its decisions. Such information may include the results of psychiatric assessment. This, and its implications for the provision and development of psychiatric services, forms the subject matter of Chapters III, IV and V.

6. Chapter VI describes the part which psychiatric services are currently playing in the treatment of offenders, in co-operation with family doctors, local authorities, probation officers, penal institutions and approved schools. Chapter VII proceeds to discussion of the development of psychiatric services for the treatment of offenders.

7. Chapter VIII takes up the subjects of training and research in forensic psychiatry, stressing the importance of the university contribution to each of these fields.

8. Chapter IX contains a summary of our main conclusions and recommendations.

9. Further information on the legal background to forensic psychiatry may be found in the Mental Health (Scotland) Act 1960<sup>1</sup> and the Notes relating to Part V of this Act<sup>2</sup>.

## CHAPTER II

### The Potential Contribution of Psychiatric Skills and Services

10. Before examining the adequacy of existing services and making suggestions for their improvement, we have thought it desirable to have a preliminary review of the assistance which psychiatric skills and services might, on present knowledge, be able to give in the field of assessment and treatment of offenders. This is a complex question in which there are substantial uncertainties; it will assist the understanding of the more detailed parts of our Report if we set out our general approach to it at this stage.

11. We are concerned about the too high expectations which some of the other services, possibly encouraged by the extensive claims of a few psychiatrists, have formed of the potential effectiveness of psychiatry in the treatment of the offender. There is an attitude that can be summarised in the statement: "Because we can do nothing with this offender, he must be mentally ill, and therefore within the province of the psychiatrist". We can see no basis for a proposition that, because other skills have failed, psychiatry can, or ought to be able to, provide the answer. Our own view of the potential contribution of psychiatry at the present time is a more modest one.

12. Our discussion falls into two distinct parts. The first relates to the contribution which the psychiatrist, as an individual possessing certain professional skills, may be able to make; the second to the contribution of the psychiatric services, in which there are added to psychiatric skills as such the facilities of the mental and mental deficiency hospital and the powers of compulsory treatment under the Mental Health (Scotland) Act 1960.

#### **Mental Disorder and Criminal Tendencies**

13. Understanding of the question has not been assisted by a certain belief that mental disorder and criminal intent are mutually exclusive—that is, that a person can be "mad" or "bad", but he cannot be both at the same time. This does not accord with experience. There is room for almost every degree of mental disorder and of tendencies to deliberate criminal acts within the same person.

14. We are firmly of the opinion that, wherever mental disorder exists, services should be provided to remedy or alleviate it, just as in the case of physical

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<sup>1</sup> Mental Health (Scotland) Act 1960, H.M.S.O.

<sup>2</sup> Mental Health (Scotland) Act 1960; Patients concerned in Criminal Proceedings—Notes on Part V of the Act, H.M.S.O.

illness. The diagnosis and treatment of mental disorder is the function of the psychiatrist; and this function must be performed whether the mentally disordered person is an ordinary citizen or an offender.

15. But if the relief of mental disorder is the established purpose of psychiatry, in the treatment of the offender society has another purpose—that of preventing future criminal behaviour on his part. The crucial question is the extent of the link, if any, between these two purposes. Is there any reason to believe that a mentally disordered offender whose mental condition is relieved is on that account unlikely to offend further? Or alternatively can the skills developed for the relief of mental disorder help to prevent future crime by the offender, whether or not he is mentally disordered as that term is commonly understood?

16. To a limited extent it is possible to give a positive answer to the first of these questions. In a small number of cases severe mental disorder results in “crime”—leaving aside any question of a relationship of severe mental disorder and guilt—and there is little possibility of repetition if it is relieved. There are also offenders who are under stress as a result of mental disorder whose social behaviour can be expected to improve as a result of the removal of that stress. But we do not think that, on present knowledge, the question is, except to that limited extent, capable of a definite answer.

17. The second question—whether psychiatry can directly modify propensity to commit criminal offences, as opposed to the indirect contribution it can make by the relief of mental disorder as commonly understood—we approach with even greater caution. There is at present neither justification nor practical value in regarding all criminality or even persistent criminality as a symptom of mental disorder. With advances in the knowledge of human behaviour it may be that the present boundaries will be redrawn; but we think that the contribution that psychiatry is in a position to make is a comparatively restricted one and that any developments will have to be cautious and tested by experience.

18. Nonetheless, we think that there are grounds even now for looking to psychiatry for some further contributions to the treatment of offenders; areas of potential contribution which can be identified include:

- (a) the utilisation of relationships in social groups for therapeutic ends;
  - (b) the deployment of techniques for effecting personality changes, and
  - (c) behaviour therapy
- (a) An important development in mental hospital practice has been the studied involvement of patients, doctors, nurses and other personnel in regular large-group discussions, which make use of incidents in the day-to-day interactions on the ward in order to identify, understand and eventually modify pathological elements in some patients' behaviour. This planned utilisation of the living-learning experiences of behaviour in the group is the key principle of the “therapeutic community” approach, which appears relevant to the régimes of penal institutions.
- (b) Group and community therapy are two of the techniques by which psychiatrists try to modify not only patients' symptoms, but also, to some degree, their personalities. The repetition of self-defeating and anti-social patterns of behaviour has been shown, in some cases, to be rooted in faulty early relationships which have left a lasting impression upon the patient's adult personality. Techniques of individual and group psychotherapy have been evolved to help the patient to reveal the context of his

faulty learning, to re-experience its accompanying distress and subsequently to achieve a delayed personality maturation which liberates him from the repetition of his maladaptive attitudes and behaviour. Psychiatrists have learned to be cautious in their expectations of psychotherapy; personality characteristics are often deeply ingrained, and resistant to change. Nevertheless, these techniques hold out some of the best prospects of modifying personality.

- (c) Behaviour therapy employs techniques derived from conditioning and learning theory to the modification of unwelcome symptoms and patterns of behaviour. Aversive conditioning, which associates the undesired behaviour with unpleasant experiences, such as nausea and vomiting, or electric shocks, has been demonstrably effective in modifying behaviour in some cases of alcoholism and sexual deviation, but its effectiveness has sometimes proved of limited duration. Treatment of this kind, provided it is accepted on an entirely voluntary basis, may be of value in the case of certain offenders.

19. We think that the contribution which psychiatry can make to the treatment of offenders is at present inhibited by the lack of psychiatrists with experience of persons with criminal tendencies, with penal institutions and criminal procedure—the area of experience embraced in the term “forensic psychiatry”. We shall in a later chapter discuss the question of expanding training and experience in forensic psychiatry.

### **Psychiatry and the Penal Services**

20. One difficulty in defining the distinctive contribution of the psychiatrist lies in the absence of a clear line between psychiatric treatment and other treatment given to the offender. If a surgeon decides on an abdominal operation the prisoner is taken to hospital and is returned to prison when he is sufficiently recovered. The functions of surgeon and prison staff are quite separate. But the psychiatrist's functions may not be so distinct from those of the penal services; for instance, from those of the probation officer undertaking case-work. Both may, though at different levels, be building on personal interactions to help the individual who is their concern. Indeed, because of their respective personal characteristics, the probation officer may be more successful than the psychiatrist in an individual case. Also, the psychiatrist's treatment of the individual is much more directly affected than the surgeon's by other forces acting on the offender—by his being detained in prison, by the prison régime, by the way the prison service deals with him, and so on. Put another way, the psychiatrist cannot start with a clean sheet; whether it is planned or adventitious, whether it re-enforces the psychiatric treatment or otherwise, the offender in the penal situation is already undergoing “treatment” into which the psychiatrist's skills must be worked if they are to make their contribution.

21. This situation places certain limitations on the effective use of psychiatry; it also provides certain opportunities. But it raises certain organisational problems which may be unfamiliar both to doctors and to those who seek medical assistance. Where a psychiatrist decides that a certain line of treatment is appropriate for an offender/patient, the penal services will attempt, to the best of their ability, to co-operate in that treatment, but the extent to which they can do so may be limited by the requirements of their own functions, e.g.

security. On the other hand, a better solution may be found in an individual case in, say, the probation officer treating under psychiatric guidance the probationer/patient in whose case he is necessarily involved, than in the psychiatrist (or his auxiliary staff) and the probation officer both being involved in direct treatment. The same considerations, it seems to us, arise in the case of other services involved in the treatment of offenders, including for example the educational services in their dealings with juvenile offenders and their families.

22. To the psychiatrist accustomed to treating his patients either personally or by the employment of other skills within the National Health Service the suggestion that he should operate through the skills of staff employed by the penal services will appear as no novelty. In suitable cases, it appears to be an eminently sensible course which is likely to benefit the offender/patient. It is also likely to be of value to the member of the penal service so employed, widening his experience and giving him the confidence that can derive from knowing that he is working with medical support and guidance.

23. From a member of the penal services working under psychiatric guidance with the offender who, because of mental abnormality, has become a psychiatric patient, it is but a short step to that member's seeking the psychiatrist's advice in the management of an offender where psychiatric treatment as such is not indicated, but the support of a psychiatrist's experience would be helpful. We shall refer later to Connell's articles on the rôle of the psychiatrist in the approved school, which also have a relevance to other institutions. His experience suggested to him, particularly in view of the inhibitions on individual psychiatric treatment referred to above, that he could perform a useful function in this way. We accept that it could be argued that the performance of this function was not psychiatry as such; and also that it makes heavy demands on psychiatric time since it can only be effectively performed if, by frequent contact and the growth of mutual confidence between the individual psychiatrist and the institution or other unit of the penal services concerned, the psychiatrist becomes part of the unit team. But no other profession is in a better position to perform the function; and we think that it must be taken into account, in the planning of psychiatric services, as an important contribution which psychiatry can make to the treatment of offenders.

### **Treatment within the Psychiatric Services**

24. We turn now to the last clause in our remit, namely the treatment of those offenders who become the responsibility of the psychiatric services. It is therefore necessary to consider not only the part that psychiatry can play, but also the rôle of hospitals, and the use of compulsory powers under the Mental Health (Scotland) Act 1960 for the treatment of mentally disordered persons with criminal tendencies.

25. The sentiment that we have referred to earlier that, if there is no answer to the treatment of a particular offender among the penal services, there ought to be in psychiatry, also expresses itself in the form of the statement: "We should not be trying to cope with this offender in our school/borstal, etc. He should be in a hospital". We received a considerable amount of evidence suggesting that there were offenders being dealt with in the penal services, mainly in institutions, who ought to be in mental or mental deficiency hospitals; and we made a careful examination of what might be called the "grey area" between the penal and psychiatric services. We found no grounds for the view that any clear-cut

line can be drawn between offenders who ought to be in mental or mental deficiency hospitals and offenders who ought to be in institutions for the treatment of offenders, or that an offender who cannot be coped with in an institution can successfully be coped with and treated in a hospital. Indeed, with some recalcitrant and apparently disordered inmates it seems likely that the opposite is true.

26. We think that the revision of the mental health laws in 1960 created undue expectations among those concerned with the treatment of offenders about the rôle the psychiatric services might play. The Mental Health (Scotland) Act 1960 was based on the medical knowledge then available and was specifically designed to enable advances in medical knowledge to be absorbed into its procedures without fresh legislation. In particular, it included a wide definition of mental disorder to which treatment (including compulsory treatment) could be applied under the Act and, subject to certain limitations not relevant to offenders, embraced within the definition mental disorder manifested only in abnormal behaviour—the rough equivalent of “psychopathic disorder” in the comparable English Act of 1959. Some expectation arose, and was disappointed, that the problem of the “psychopathic offender” would be removed from the penal services by the provision of hospitals in which “psychopaths” would be successfully treated and by the detention of “psychopaths” in such hospitals. Whether or not the present provision of mental and mental deficiency hospitals is adequate—a point to which we will return later—those holding this expectation did not adequately appreciate that, although the 1960 Act made allowances for the advancement of medical knowledge, an Act of Parliament cannot itself advance medical knowledge.

27. There are clearly some offenders who should be treated psychiatrically in hospital and not by the penal services, and vice-versa. There is no alternative where an offender, because of the severity of his mental disorder, requires hospital care and nursing; that offender should be in hospital. Compulsory psychiatric treatment can only be imposed where a sufficient severity of mental disorder exists to warrant it; if an offender is not suffering from mental disorder or is suffering from such disorder only to a slight degree, and his detention is necessary in the public interest, then that detention can only be authorised as a penal measure by the criminal courts. However, in between these two clear cases, there exist a number in which either psychiatric treatment or penal measures can properly be applied.

28. In discussing borderline cases, it seems to us appropriate to have regard to the inherent differences of aims and objectives between psychiatrists and the penal services, between hospitals and penal institutions and between the different expectations of these professions and establishments held by the public. Psychiatrists are medical practitioners and their training has directed their aim towards the cure and relief of illness. They accept that their hospitals must contain some patients who are unlikely ever to be fit for discharge but who must continue to be detained because their mental disorder requires care and nursing or constitutes a serious risk to themselves or others. They are also willing to attempt the psychiatric treatment of those who appear, as a result of mental abnormality, not to have responded to other measures, even where the prospect of success may be judged small. But it would go against the grain for them as medical practitioners to detain for a period—perhaps the indefinite period for which, subject to reviews, compulsory psychiatric treatment may be continued—

persons who held out no prospect of responding to psychiatric treatment, unless this course was justified by the severity of their mental disorder. The penal services, in contrast, are geared to treating and supervising an offender for a fixed, or fixed maximum, period decided beforehand; their aim is to make successful use of the period. But, particularly with fixed periods of detention, they must continue to treat and supervise even where they are conscious that the offender is not responding and is perhaps becoming more, rather than less, likely to commit criminal acts in future because of the effect of the court's sentence upon him.

29. There are parallel differences between hospitals and penal institutions. Mental and mental deficiency hospitals are directed to the relief and alleviation of mental disorder and to the discharge of patients to the community as quickly as their improved mental condition warrants. For this reason they must have regard, insofar as they have an element of choice about whether a patient should be admitted or not, not only to his treatment, but also to the likely effect of his admission on the treatment of the other patients. Penal institutions on the other hand have generally no control over their admissions—though there may be some selective placement between institutions. The purpose of the admission to the institution is normally expressed as being detention there for a period rather than treatment as such.

30. The purpose of admission—or, more especially, the public expectation of that purpose—is also relevant. In general terms admission to hospital implies no blame or punishment; even when, as in the minority of cases, compulsion is used, it is for the purpose of treatment and should last no longer than that treatment requires; penal measures are always compulsory and carry a necessary implication of punishment. They are generally seen as punishment, so that they may be justified even if they do harm rather than good to the individual concerned. This will have psychological consequences for the person detained. While the public rightly hold the psychiatrist responsible for any apparent disregard for the public's safety in the care and supervision of the mentally disordered in their hospitals, the psychiatrist has wide discretion—by relaxations of supervision, by home visits and leaves of absence—to test out the patient's response to treatment and suitability for discharge, and thus to hasten the time at which he is fit for discharge. The actual date of discharge is decided upon the evidence at the time of his response to treatment and fitness for return to the community; it is not laid down, nor substantially governed by, decisions made before admission. As punishment, penal measures are, with few exceptions, of fixed duration, so that the offender must be discharged on expiry of a sentence, whether, from the treatment point of view, it is a good moment or a bad one for him to return to the community. In cases dealt with by detention, deprivation of liberty is generally accepted as the main punishment; the use of home visits, leaves of absence, etc., are in conflict with deprivation of liberty, and their use accordingly inhibited. On the other hand, because penal institutions are regarded as places of punishment, they can operate a strictly disciplined régime based on rewards and punishments which the public would not accept in a mental hospital.

31. We do not consider these differences will necessarily always exist in the form in which they do at present. It is possible to envisage a penal institution with as considerable a discretion about temporary leave as a mental hospital; and equally so a mental hospital run on a strict system of rewards and sanctions which might be accepted as appropriate for the treatment of certain types of

mentally disordered persons. But advances in the knowledge of what effect treatment of such individuals has, whether it is treatment for mental disorder or criminality, have proved so slow that we think it reasonable to assume that present public attitudes and their effects are likely to last for a long time.

32. The point we wish to stress is that it is not possible to separate out certain psychiatric skills and skills of the penal services from the institutions in which they are applied and the surrounding circumstances which affect their application. It seems to us possible that, leaving aside any question of the relative professional contributions, an offender might respond to detention for compulsory psychiatric treatment in the régime of a mental hospital who would not respond to detention as punishment in a penal institution; and vice-versa.

33. We shall later discuss the actual cases in which it is suggested that psychiatric services are not playing their full part—particularly the question of the treatment of the “psychopath”. Psychiatric diagnosis has an important part to play in the decisions on borderline cases; and psychiatric treatment may be called for even if the offender remains within the ambit of the penal services. But, for the reasons given above, we do not think that the decision on whether the individual offender should be in prison or hospital can be reached merely on a classification of the offender by the severity of his mental disorder. (Nor is such a categorisation much more helpful if—as unfortunately may be the case—it appears likely that he will respond neither to psychiatric nor penal treatment). In our view, this decision must turn on an estimate of which service—penal or psychiatric—is likely to be most effective in the case of the individual concerned.

## CHAPTER III

### Psychiatric Reports to the Court—the Statutory Background

34. The criminal court, when considering the evidence of a psychiatrist, is usually looking for assistance in one or more of three areas, namely on the fitness to plead of an accused, his state of mind at the time of the crime, and finally how (after he has been adjudged to have committed an offence) his case might best be disposed of. At various stages before deciding on disposal, the court may remand the accused, either to a specified place such as a prison or hospital, or with no such limitation except possibly a requirement of bail.

#### **Fitness to Plead**

35. It is a rule of law that no man may be tried for a criminal offence who is insane, and whose insanity is such that he is unable rationally to plead or to instruct his defence. (This old term insanity may in the present context be taken as the equivalent of severe mental disorder). Hence, if the procurator fiscal or the defence suspect such insanity in an offender, either party may arrange medical examination directed towards determining his fitness to plead. It is usually the procurator fiscal who takes such an initiative. If his medical reports point to unfitness to plead, it is customary for him to make them available to the defence. Prosecution and defence almost invariably reach agreement on this issue. Even so, if their conclusion is that the offender is unfit to plead, this must be supported

by the evidence of two expert medical witnesses, who moreover must appear in person before the court, there to speak to their reports and answer questions which may be put to them by judge, prosecution or defence.

36. The law requires that a court, on finding an offender unfit to plead, shall order his detention in hospital. The nature of the order depends to some extent on the gravity of the offence, as well as on the offender's personal characteristics. Thus, if his was a sufficiently serious case to be taken *on indictment*, the offender will be made the subject of an order which not only commits him to a mental or mental deficiency hospital, but which also has the effect of an "order restricting discharge" of indefinite duration. (This term is explained later). His committal will moreover be to the State Hospital at Carstairs, where he will be treated under conditions of high security, unless the court for special reasons specifies another hospital. On the other hand, if his was a less serious case and therefore dealt with by *summary* procedure, the offender will be made the subject of an order which commits him to a specified mental or mental deficiency hospital, with or without an "order restricting discharge" at the discretion of the court, and more often than not a hospital other than the State Hospital—the latter may, however, still be specified in the order if the court has come to the conclusion that on account of his dangerous, violent or criminal propensities the individual requires to undergo his treatment under conditions of special security and cannot suitably be cared for in any other hospital.

37. Thus a court may require of the psychiatrist his opinion on an offender's fitness to plead; plus, in an indictment case, his opinion on whether there are grounds for committing the offender to a hospital other than the State Hospital, and, in a summary case, whether or not the order committing the offender to hospital need include a clause restricting his discharge, and which hospital should be named in the order.

### **Diminished Responsibility; Insanity at the Time of the Crime**

38. A person found to have killed another in circumstances which would normally constitute murder may instead be convicted of the lesser crime of culpable homicide if, at the time of the crime, his responsibility for his actions was substantially diminished by mental abnormality. The restriction and subsequent suspension of the death penalty as the fixed penalty on conviction of murder has reduced the number of cases in which a plea of diminished responsibility is raised. Even less frequently (i.e. about once a year) will a person be found fit to plead yet "insane at the time of the crime", a verdict which leads to his committal to the State Hospital or other mental hospital.

39. At least two psychiatrists, attending in person to speak to their reports on the accused, are required to give evidence to the court before the issues of diminished responsibility or insanity at the time of the crime are put to the jury.

### **Disposal**

40. This is the term generally recognised as covering the various possibilities open to the court when dealing with those individuals who are brought before it. These possibilities, on which there are naturally certain limitations according to the age and other personal characteristics and circumstances of the individual the court has under consideration, and the offence(s) with which he is charged, include the following:

- (1) deferring sentence (with or without conditions);
- (2) admonishing;
- (3) imposing a fine;
- (4) putting on probation (with or without conditions);
- (5) committing a person under sixteen to an approved school;
- (6) committing those aged sixteen to twenty-one to borstal for training designed to develop character, ability and sense of personal responsibility;
- (7) committing youths aged seventeen to twenty-one to three months in a detention centre, where the régime is one requiring a high standard of alertness, personal conduct, cleanliness, physical fitness and work effort;
- (8) sentencing those aged seventeen to twenty-one who require custodial treatment but for whom the other disposals mentioned above are inappropriate to a period in a young offenders institution;
- (9) sentencing those aged twenty-one and over to imprisonment; and
- (10) committing those with mental disorder to hospital or guardianship.

41. A medical practitioner who has been requested to examine an offender may not infrequently be stating his conclusions in words such as: "In this instance I find no evidence of any psychiatric disorder which requires or is susceptible to treatment" or "If the accused is found guilty I would not recommend any psychiatric disposal, and I see no medical reason why he should not be dealt with under the other methods of disposal available to the court".

42. In other cases, however, he may conclude with a specific recommendation such as probation with a condition of psychiatric treatment or compulsory admission to hospital or guardianship under one of the sections of the Mental Health (Scotland) Act 1960. This Act, and section 3 of the Criminal Justice (Scotland) Act 1949, which deals with probation, are known thoroughly by those regularly concerned with forensic psychiatric practice. The remaining paragraphs of this chapter are not to be taken as an interpretation of these Acts, but merely as an introduction for those with no previous knowledge of this subject, sufficient to enable them to follow the ensuing chapters of this Report.

43. The criminal court is normally given a very wide discretion to select an appropriate disposal for the offender convicted before it; and is under duty, advised and assisted as it thinks fit, e.g. by a probation officer's social enquiry report, to select the best possible disposal. In the case of some disposals, however, the law lays down that certain pre-conditions must be satisfied before the court may order that disposal; for instance, the court may not impose imprisonment on an adult first offender unless and until it has obtained and considered a report on the offender's character and background and is of opinion that no other disposal is appropriate. This distinction between a general duty on the court to order the best disposal and a legal requirement that certain conditions must be satisfied before certain disposals can be ordered, is relevant to the functions of a psychiatrist in relation to court disposals.

44. In the case of three disposals—compulsory detention in hospital, compulsory reception into guardianship, and placing on probation with a requirement to undergo mental treatment—the disposal cannot be ordered unless the court has before it appropriate psychiatric evidence. By the provisions of section

55 of the Mental Health (Scotland) Act 1960, the court can (except where, as in murder, the penalty is fixed by law) make a "hospital order"—an order for compulsory detention in hospital—or a "guardianship order"—an order for the reception of the offender into compulsory guardianship—in respect of any offender convicted before it of an offence punishable with imprisonment. But, before it can make such an order, it must have the evidence of two medical practitioners, one of them a practitioner having special experience in the diagnosis or treatment of mental disorder, that the offender is suffering from mental illness or mental deficiency, or both, and that the disorder is of such a nature or degree as to warrant the offender's detention in hospital or reception into guardianship, as the case may be. The court must also be satisfied that a place in an appropriate hospital is, or will shortly be, available or that appropriate arrangements for guardianship have been made.

45. Under section 60 of the 1960 Act, the court may add to the hospital order an "order restricting discharge" or restriction order. The court does this only when it considers it necessary for the protection of the public. In coming to this opinion the court has regard to the nature of the offence, the antecedents of the offender, and the risk that as the result of his mental disorder he would commit further offences if set at large. The effect of a restriction order is that the Secretary of State (and not, as in the case of other mental patients, the psychiatrist responsible for the patient) takes subsequent decisions relating to the detention of the patient which affect public safety. Thus a patient may not be discharged, given leave of absence, or transferred to another hospital without the consent of the Secretary of State. The court may make the restriction order of unlimited duration, or (though this is rare in practice) for a specified number of years, but in either case the Secretary of State may at any time lift the restrictions. Whereas, if the defence agree, an order under section 55 may be made on the written evidence from the medical practitioners concerned, oral evidence from one of the medical practitioners is required before an order under section 60 can be made; and that medical practitioner must be one with special experience in the diagnosis and treatment of mental disorder.

46. Under section 3 of the Criminal Justice (Scotland) Act 1949, a court, in making a probation order, may, with the offender's consent, add to the order a requirement that he undergoes treatment as a mental patient, on either an in-patient or an out-patient basis. Before the court adds such a requirement, it must have the evidence of at least one experienced medical practitioner that the offender's mental condition is such as requires and may be susceptible to treatment, but not such as to warrant his compulsory detention in hospital under section 55 of the 1960 Act. The court must also be satisfied that facilities are available for the treatment ordered. The medical evidence may be in writing if the defence agrees.

47. Section 55 of the Mental Health (Scotland) Act lays no legal compulsion on the court, but gives it discretion to make a hospital or guardianship order where, after receiving the necessary medical evidence, it is of opinion having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of such an order. This accords with the practical situation. There will be persons convicted before the court whose mental disorder is severe, so that there can be no question of disposal other than by orders which will procure for them

the required treatment. But there are borderline cases where there is a real choice between a medical disposal and one of another kind; and the court must decide which is the most appropriate disposal in the light of such considerations as, for instance, the offender's need for medical treatment and the possibility that medical treatment or some other form of disposal is more likely to ensure that he refrains from further offences.

48. This is a decision for the court alone to take, though it can seek the advice and assistance of a psychiatrist in reaching its decision. Clearly, the psychiatrist's view must have great weight in any consideration by the court of the offender's need for mental treatment and of the likelihood that treatment for his mental disorder will be effective.

49. As stated earlier, a medical disposal can only be ordered if the facilities for carrying out the treatment are available—in particular, a place in the hospital to be named in a hospital order. This places a practical restriction on the court in deciding the best possible disposal; it is another field in which the psychiatrist can be of assistance to the court. He it is who will know, or will be in a position to ascertain, whether a suitable hospital has a vacancy for the offender. Thus he can assist the court by advising it on the likely effects, not of treatments which might theoretically be applied to the offender, but of the treatments which are in practice available.

50. The psychiatrist's functions in relation to fitness to plead and in relation to possible disposal are frequently telescoped, as a matter of practical convenience. A psychiatrist asked to examine an accused person with regard to his fitness to plead, may form the opinion that, although fit to plead, his condition is such that, if convicted, he is a person appropriate to a medical disposal; he so reports to the procurator fiscal, who brings this to the attention of the court. On occasion however it may be necessary for the psychiatrist's report to be supplied in two parts, the first dealing with the accused's fitness to plead and the second with disposal.

51. The complexity of the subjects touched on in this chapter, and the differing approaches to them of legal and medical professions, make it inevitable that there should be the occasional, though fortunately rare, clash between judge and expert psychiatric witness. The latter, by being particularly rigorous in his thinking and expression, may keep such conflict to a minimum. The psychiatrist who is comparatively inexperienced in court work may find more detailed guidance on pages 17 to 19 of the Notes on Part V of the Mental Health (Scotland) Act, under the heading "Considerations which doctors giving medical evidence should have in mind".

## CHAPTER IV

### Psychiatric Reports to the Courts—the Present Position in Scotland

52. Fifty years ago it was unusual for psychiatric opinion to be sought and led in evidence before the courts for any purpose beyond that of helping to determine the fitness to plead of some of those charged with major crimes.

Legislation such as the Criminal Justice (Scotland) Act 1949 and the Mental Health (Scotland) Act 1960, pressure of a changed public opinion, and greater confidence in the psychiatrist have led the courts to widen their demands upon him. Thus today the psychiatrist is regularly requested to report on those charged with less as well as more serious offences, and with reference to disposal as much as to fitness to plead or degree of responsibility. Moreover, to quote from the evidence submitted by the Council of the Sheriffs Substitute Association, "The value of (psychiatric) reports submitted to the courts has increased considerably in recent years as mutual confidence between court and doctor has grown".

53. In 1964 psychiatrists were meeting requests for some 1,700 reports per annum for the Scottish courts, which amounts to 33 psychiatric reports per 100,000 population. From this average there are wide area variations, psychiatrists based in the respective hospital regions providing, per 100,000 of their populations, the following numbers of reports per annum:

|               |    |
|---------------|----|
| Western       | 38 |
| Eastern       | 25 |
| North-Eastern | 23 |
| South-Eastern | 23 |
| Northern      | 20 |

54. Because more than one psychiatric report is sometimes supplied on the same offender, it can be inferred from the above figures that, on average, there are in each 100,000 of the Scottish population 25 to 30 individuals who will in the course of a year be the subjects of psychiatric reports to the courts. From the level of referrals by the police to the Mental Health Section of Edinburgh Public Health Department, it may also be inferred that, in a 100,000 unit of population, there are an additional 5 to 10 persons who, whilst not the subjects of psychiatric reports to the courts, are referred by the police to the mental hospital, social services or family doctor.

55. We attempted, on the basis of statistics supplied by the Procurator Fiscal Society, to estimate in what proportion of common law offences and serious statutory offences tried by the Scottish courts recourse was made to a psychiatric report. The indefinite nature of the term "serious statutory offence" may be part cause of three of the Sheriff Court Districts (namely Cupar, Paisley and Perth) returning figures showing their proportions to be two or three times the level in the five other districts which were able to supply the necessary data. This latter proportion, which seemed fairly representative of Scotland as a whole (being arrived at separately for each of the Sheriff Court Districts of Edinburgh, Forfar, Kilmarnock, Lanark and Linlithgow) was between 2 per cent and 3 per cent of those tried for such offences. Figures supplied by Ayr and Edinburgh provided the additional information that in the cases of between one-third and one-half of the offenders reported on by psychiatrists to their sheriff courts, the latter made orders for compulsory admission to hospital under the Mental Health (Scotland) Act.

56. How is it decided whether or not an offender before the court shall be reported on by a psychiatrist? In a minority of cases, this decision is taken either by the sheriff or by the defending lawyer, the latter if necessary meeting the costs of such examination through Legal Aid. More often, however, the decision is

taken by the procurator fiscal who requests psychiatric examination when he feels it is desirable in the light of:

- (a) the facts he receives from the police about either the accused or the nature or circumstances of the crime with which he is charged;
- (b) the statements of witnesses showing the accused to have a history of mental disorder; or
- (c) an intimation from the accused's solicitor that psychiatric examination of his client is indicated.

The above sources of information also enable the procurator fiscal to make his choice between asking for the initial psychiatric examination to be carried out by a specialist in mental illness or one in mental deficiency.

57. Procurators fiscal and sheriff clerks (acting for sheriffs), as the groups most often requesting psychiatric reports, were largely satisfied with these existing arrangements, especially as they retained under them the right to instruct a psychiatrist of their choice (in practice they usually found it best to contact a psychiatrist from the mental hospital or mental deficiency hospital in whose catchment area the accused normally resided). Those court officials operating in the West of Scotland were not however entirely content with the present position. Their observations included that of psychiatrists failing to return their reports to time or writing them without sufficiently strict regard to the purpose for which they were required (the procurator fiscal who raised this point accepted, however, that he also had a duty to make explicit his reason for requesting a psychiatric examination); the expenditure of their time in determining the "hospital catchment area zone" in which an accused normally resided as a preliminary to their choosing a psychiatrist to submit a report on him; and on occasion delay in the implementation of the disposal decided on by the court, particularly if this was for committal to a mental deficiency hospital or the State Hospital.

58. Psychiatrists too have their points of criticism. Particularly when examining an accused remanded in legalised police cells, they are often denied that quietness and freedom from interruption necessary for proper assessment. They are asked at times to submit a report in a much shorter period than they consider reasonable—extension of remand may be granted by the court on request, but where the accused is remanded in custody this may lead to his being detained longer than is in his or the public's interests. They expressed most concern, however, that in some areas they were not supplied with sufficient background information on the accused, nor given a sufficiently clear indication of the purpose for which the report was sought for them to be able adequately to meet the needs of the court.

59. Only a small minority of accused persons are detained, either in police or prison custody, or in hospital pending trial. We are satisfied that current provisions safeguard the obviously mentally ill person from being detained in prison when instead he should be in hospital. The accused person's mental state may be the subject of enquiry at the following points:

- (1) On first encounter, when he may be taken straight to hospital or to the mental health officer by the police or other agency.
- (2) At the police station, where his case may be notified by a police

officer or the police surgeon to the mental health officer. The latter, in consultation with a medical practitioner (usually a psychiatrist), may arrange his informal or compulsory admission to hospital.

- (3) On first or subsequent appearance before the court, when, on medical evidence, his compulsory detention in hospital on remand may be ordered for up to three weeks at a time for further investigation into his mental or physical condition.
- (4) At various stages in the legal proceedings by psychiatric examination at the request of the sheriff, procurator fiscal or defending lawyer.
- (5) Finally, if remanded to a prison, he will be examined by and will continue under the care of the institution's medical officer, who will advise the procurator fiscal (through the governor) of any case in which mental disorder develops or only becomes apparent during remand in custody.

### Children and Young Persons

60. The relevant legislation defines a child as being under fourteen years of age, and a young person as having attained that age but not yet having reached seventeen years. As services for these two age-groups can not be sharply separated, we take them together in this section.

Child psychiatrists stated that:

- (a) they could usefully supply reports on more child offenders than were being referred to them by the courts, and
- (b) they would do this generally after out-patient assessment, thus avoiding having the child remanded in custody as far as possible.

61. Various indicators of how infrequently child psychiatrists are consulted by the courts may be quoted. Of over five hundred referrals to one Department of Child Psychiatry, less than 2 per cent had been for the purpose of obtaining psychiatric reports for the court. Again, the courts, in coming to their decisions about the disposal of 4,000 children admitted to Scottish remand homes, obtained psychiatric reports in 4 per cent of cases only. That this, moreover, was a universal practice (apart from Aberdeen, in whose remand home 16 per cent were examined by a psychiatrist) was shown by the fact that not one of the remand homes in Dumbarton, Dundee, Edinburgh, Glasgow or Lanarkshire was having more than 6 per cent of its children reported on by a psychiatrist.

62. It is to be noted, however, that *every* child in a remand home is examined by:

- (a) The medical officer to the institution—such medical officers themselves supplied reports to the court on 35 per cent of the 4,000 children, and initiated referrals to child psychiatrists or psychologists where they considered additional reports from such specialists to be necessary; and
- (b) Either the children's officer or a probation officer who, when reporting on a child, necessarily refers to the education authority for the area from which the child came. Some education authorities when meeting such an enquiry furnish additional data such as may be found in the child's school, school health or child guidance record—there are other areas, however, which do not so readily make available to the court such detailed background information.

## Psychiatric Reports to the Courts—Recommended Developments

63. In the previous chapter we gave it as our opinion that current provisions safeguard the obviously mentally ill person from being committed to prison when instead he should be in hospital. That however is a limited goal. In this chapter we look further ahead, to outline developments of existing procedures by which a generally more effective psychiatric service may be made available to the Scottish courts.

64. We expect that the majority of psychiatric reports to the courts will continue to be supplied by consultants in general psychiatry. We look now at the passage of an offender, from the time of his first confrontation by the police up to that when his disposal is ultimately decided on by the court, as a framework within which to set down our recommendations on this part of our remit.

### Police and Police Surgeons

65. When the police take into custody a person suspected of being mentally ill or mentally defective, they are accustomed to obtain information from general practitioner and local authority. The latter's services are expanding and we recommend the police to make increasing use of them in the future, i.e. more frequently to consult the medical officer who is dealing with mental health matters or the mental health officer. These local authority personnel, from their knowledge of the area's psychiatrists and facilities, may be able to arrange care and treatment for the minor offender. The procurator fiscal may then sometimes find himself able to discontinue or suspend proceedings, thereby avoiding unnecessary remand in police cells or prison. There is power in section 104 of the Mental Health (Scotland) Act 1960 for the police to take mentally disordered persons found in a public place directly to hospital; and the ordinary procedures of the Act, e.g. the emergency medical certificate, can also be used to ensure that they are looked after without unnecessary resort to criminal procedure. The police of one area consult their local authority a hundred times a year about mental health problems they meet in their half million population.

66. The police surgeon or other doctor who examines a person accused of either a minor or a major offence should also remember the possibility of action under section 54 of the Mental Health (Scotland) Act. This provides that, on the evidence of a medical practitioner, a court may commit on remand to an available and suitable hospital a person charged with an offence who appears to it to be suffering from mental disorder, to cover a period which will not be longer than that for which the person might otherwise have been remanded in custody. This permits observation of the accused before reporting on him. One mental hospital is admitting fifty patients a year on this basis.

### The Regional Hospital Board

67. One function only of the Regional Hospital Board is considered at this juncture. Each board already compiles a list of those medical practitioners in its region who, in the words of section 27 of the Mental Health (Scotland) Act, are "approved by a Regional Hospital Board as having special experience in

the diagnosis or treatment of mental disorder". Procurators fiscal are amongst those who receive a copy of this list, and are accustomed to refer to it when deciding which practitioner or practitioners to approach for a psychiatric report on an accused. In the large centres of population, where in the course of a year a procurator fiscal may be dealing with a number of different practitioners, it is difficult for him, with the lists in their present form, to be sure he is always communicating with the medical colleague best placed to report on a particular offender. We favour retention by the procurator fiscal of his right to request the report from the medical practitioner, hospital or other psychiatric facility (such as an out-patient clinic) of his choice, but to enable him to do this more effectively, we recommend that, against the name of each doctor on their "Section 27" list, the Regional Hospital Board should include a clear statement:

- (a) Whether his work is principally in general psychiatry (within which term we include, for this purpose, work with adolescents as well as with adults), mental deficiency or child psychiatry.
- (b) Whether he has access to facilities in a hospital, and if so a broad indication of its catchment area.
- (c) The basic information on address and grading which these lists at present carry.

### **The Procurator Fiscal**

68. The procurator fiscal, at the time of calling for a psychiatric report, will from the information he already has about the offender's age and probable intelligence know whether to contact a specialist in general psychiatry, mental deficiency or child psychiatry; moreover, when he anticipates the possibility of the examining medical practitioner recommending admission to hospital, he will weigh the advantage of calling for his report from a psychiatrist with beds at his disposal. He will thereby avoid the frustration of receiving a report from one medical practitioner recommending admission to another colleague's hospital which, however, subsequently proves unable to admit the patient. The type of case where admission to hospital seems a remote possibility might be referred to any doctor "approved" by the Regional Hospital Board for the purposes of the section 27 list, except that the procurator fiscal might bear in mind that most of the general practitioners whose names appear there would not expect to be called on for this purpose, and those local authority doctors on the list would be able to help more with the mentally defective for whom guardianship is contemplated than with others. Clearly, there will be times when a medical practitioner carrying out a first psychiatric examination of an offender will recommend to the procurator fiscal another colleague from whom a second psychiatric report should be requested.

69. We rejected an alternative by which the procurator fiscal, instead of communicating direct with the examining medical practitioner, passed his request for a report to the Regional Hospital Board, leaving that body to choose and contact the doctor. Such an arrangement would prevent the procurator fiscal from exercising his right of choosing the doctor himself; would involve the Regional Hospital Boards in additional work the net result of which would be to retard and not to expedite the judicial process; and, through the interpolation of this extra agency, would inhibit the passage of confidential information between the procurator fiscal and examining medical practitioner.

## **Information from Procurators Fiscal**

70. While procurators fiscal in some parts of Scotland regularly supply the psychiatrist from whom they seek a report with much valuable information about the case, there are those in other areas who are not doing so. In our opinion the psychiatrist needs always to be informed on:

- (a) The reason for requesting a psychiatric examination;
- (b) any available background information about the accused, e.g. of the sort which a probation officer or other social worker includes in a "social background report";
- (c) some detail about the alleged offence, for this (subject to proof) is important evidence to the psychiatrist of the behaviour of the accused at the time;
- (d) the name of any other psychiatrist who is working on the case and of any probation officer or other social worker, and of the family doctor, if known.

71. We appreciate there may be reason for hesitation about the provision to psychiatrists of information about the crime obtained from the criminal investigation. But we have been informed that it is not in conflict with the general principles of the administration of the criminal law for the prosecutor to provide the psychiatrist from whom he has requested an examination with information so obtained. The information will be provided to the psychiatrist in confidence, and will be of the type referred to in the preceding paragraph, i.e., concerned with matters relevant to the psychiatric examination. As said above, we are recommending the continuation of direct communication between prosecutor and medical practitioner, which should enable all necessary data to be exchanged.

72. We appreciate also that, in fairness to the accused, it is desirable to keep the period of remand down to a minimum. When, however, procurators fiscal require a psychiatric report they will get a better one if, say, three weeks rather than one week can be allowed for the psychiatrist and the other agencies involved to pursue their enquiries. As remand in cases where a psychiatric report is required can usually be on bail, or perhaps under a section 54 order whilst the accused is in hospital, and only in special circumstances needs to be in police or prison custody, a fortnight longer in securing ultimate disposal will in most of these cases cause little hardship to the accused.

## **The Court**

73. Some of the points made above, concerning developments by which psychiatric and procurator fiscal services may achieve more together, are of particular relevance also to the decisions taken by the court. Thus, when a psychiatrist specialising in mental deficiency, and with access to such beds, recommends the admission of an offender to his hospital, this facilitates implementation of the court's order if it decides, in the light of all the considerations in the case, to accept that specialist's advice. Again, when the court instead of the procurator fiscal is asking for a psychiatric report, it may take into account considerations concerning choice of psychiatrist and exchange of information with him similar to those detailed above. There are certain additional developments, however, which would involve the court more than others concerned, and we now state our opinion on these.

74. There is first the question whether, when a psychiatric report is required, remand should or should not be in custody. We pass on, with our agreement, the views of psychiatrists that they can work to either such form of remand, but they consider that they can make better assessments if they see the offender on an out-patient basis where possible. This improves their chances of seeing not only the offender but also members of his family who may attend the psychiatric clinic with him; and also enables them to assess him in a more natural setting than that offered by a remand home, police cells or penal establishment. Child psychiatrists, even more than others, depend on access to the family of an offender and seeing him in a setting which is not too remote from his customary environment, and their needs in these two respects require to be taken into account when they are asked to report on the young delinquents. The statutory basis for remand for enquiry into the physical or mental condition of an accused is section 27 of the Criminal Justice (Scotland) Act 1949. It gives the court power to remand for periods up to three weeks at a time a person who they are satisfied has committed an offence punishable with imprisonment; and if granting bail to make it a condition that the accused shall undergo medical examination at such place or by such medical practitioner as may be specified.

75. Second, in a large centre of population such as Glasgow and the neighbouring counties, the number of different sheriffs requesting reports from a particular psychiatrist may, in the course of a few years, run to double figures. They may have differing expectations of him. Thus one may be looking for no more than a psychiatric opinion on whether the offender suffers from mental disorder of a nature or degree which warrants his compulsory detention or reception into guardianship, while another may be seeking more general psychiatric assistance regarding disposal. Section 27(4) of the Criminal Justice (Scotland) Act 1949 lays on the court a duty, where it adjourns a case for a psychiatric report regarding disposal, of informing the psychiatrist of "the reasons for which the court is of opinion that an enquiry ought to be made". If courts convey more of their precise requirements under the provisions of this section, psychiatrists will be able to improve the value to the courts of the reports they submit.

76. Third, in deciding on the disposal of an offender with mental disorder, courts and psychiatrists might keep in mind the possibility of putting him under a Mental Health (Scotland) Act "guardianship" order, as an alternative to the other measures such as admission to hospital which they much more commonly employ. The mental defective offender, whose misbehaviour has not taken too serious a form, may sometimes prove a suitable subject for guardianship. Where a first psychiatric report from a specialist in mental deficiency has recommended such a course, the sheriff may find it advantageous to proceed by obtaining a second medical report from a medical practitioner (on the Regional Hospital Board's section 27 list) who is on the staff of the local health authority. This medical practitioner, in consultation with his local authority, might advise whether it would be willing to be named as guardian or would take responsibility for choosing or accept as suitable whoever else was to stand in this capacity. This is another field in which, with the expansion in their community services, local authorities may be able to give increasing help with offenders in future years.

77. Fourth, when a sheriff has passed a sentence or made an order on an offender, it is necessary for the work of those whose responsibility he next

becomes that they should receive, with the offender, copies of reports such as those made on him by a psychiatrist or any other doctors involved. We recommend that the sheriff clerk should dispatch such medical reports to the medical officer of the hospital, clinic, approved school, prison etc. in whose care the offender is to continue. We appreciate that steps have been taken in this direction.

78. Fifth, we would draw attention to the anomaly by which a medical report requested by a procurator fiscal attracts a fee, yet one requested by a court does not.

### **The Probation Service**

79. The Social Work (Scotland) Act 1968 provides for the amalgamation of the probation service and other social work services into a local authority social work department. However, the functions of the probation service will continue to be carried out and, for convenience, we retain the term here and later in our Report.

80. The probation officer is the person most frequently concerned with the making of reports to the courts. Often, when a psychiatrist is asked to make a report, a probation officer's social enquiry report is called for at the same time. This could lead to unnecessary duplication of work and conflict between the two reporters; but it is our general impression that liaison is good. In particular, since the gathering of social background information is one of the main functions of the probation officer, he is able to assist the psychiatrist, who seldom has such good facilities at his own hand, by the provision of this information. We understand that probation officers often help in this way even when a probation officer's report is not called for. In return, the psychiatrist can assist the probation officer in his assessment of the offender by making available to him his own expert opinion on the offender's mental condition.

81. On one point some psychiatrists expressed their dissatisfaction. This related to a practice by which, if, during an investigation for the purpose of a social enquiry report, the probation officer came across indications that a psychiatric examination might be desirable, he attempted to arrange the examination direct with a psychiatrist instead of reporting his view to the court. Our opinions on this and other aspects of the relationship between psychiatrist and probation officer are:

- (a) Where, during an investigation for a social enquiry report, a probation officer finds evidence which suggests to him that a psychiatric examination may be desirable to assist the court to decide disposal, he should report this to the court (via the clerk) so that the court may order an examination, rather than arrange such an examination by himself.
- (b) The optimum sequence—the necessary time being available—for co-operation between the psychiatrist and the probation officer when the court has asked for reports from both might be on the following lines:
  - (i) The probation officer obtains social background information and supplies it to the psychiatrist.
  - (ii) The probation officer and the psychiatrist reach their provisional assessments and inform each other of those assessments; and consult each other if appropriate.

- (iii) The probation officer and the psychiatrist, after adjusting their own assessments as necessary in the light of the other's findings, prepare separate reports for the court.

### **Other Authorities**

82. We would draw the attention of all those responsible for providing for offenders on remand in custody or on some other residential basis (including those with administrative responsibility for remand homes, legalised police cells, remand institutions and prisons) that, to enable visiting psychiatrists to carry out their examinations of selected accused persons effectively, they should:

- (a) Supply a quiet office in which assessment can proceed free of unnecessary interruption; and
- (b) nominate a member of the institution's staff whose duty it would be to put before the psychiatrist any reports (including those based on observations of the accused whilst resident there) they possess on him.

### **Social Work (Scotland) Act 1968**

83. Finally, in considering the developments outlined in this chapter we have been aware that the services with which they deal will be profoundly affected—particularly in so far as they relate to children and young persons—by the implementation of this legislation. The form, scope and staffing of the new local authority departments for which it provides were not sufficiently developed at the time we were working on this Report. We have therefore felt unable to attempt any more detailed comment. We recognise and welcome, however, that the arrangements are likely to involve increased work on the assessment of persons in need, particularly children, and therefore to make increased demands on psychiatrists.

## **CHAPTER VI**

# **Psychiatric Services and the Treatment of Offenders—the Present Position**

### **Community Services involving the General Practitioner, the Local Authority and the Psychiatrist**

84. The general practitioner, from his knowledge of families under his care, is often in a position to observe signs of a patient (especially a child or adolescent) entering the "pre-delinquent stage", which for the purposes of this Report we do not attempt to define precisely, though as its name suggests it implies unequivocally delinquent attitudes which have not yet resulted in behaviour on which a court has come to a finding of guilt. The general practitioner, when he considers that such a pre-delinquent requires assessment or treatment by a psychiatrist, arranges an appointment, almost invariably through a child or adult psychiatric clinic under Regional Hospital Board administration. A high proportion of referrals to child psychiatrists are of patients with behaviour disorders, many of which are manifestations of pre-

delinquency, and the same holds good for a smaller yet still appreciable proportion of referrals to general psychiatrists working with adolescents and adults. General practitioners are one of the three main sources of referrals to the Glasgow Forensic Psychiatric Clinic.

85. The psychiatric services, in co-operation with general practitioners and local authorities, are already making a big contribution to the treatment of offenders in the community. The measurement of the extent of this contribution is however very difficult. Thus Philip and McCulloch (1966) have shown how certain sectors of a city have high rates of attempted suicide, truancy and delinquency. We would add that any of these three variables may constitute the crisis which brings a family in such a sector into psychiatric treatment. Appropriate treatment may have a more general preventive effect.

86. Again, delinquency is often just one part of the care and treatment problem presented by an individual for which a local authority has a degree of responsibility through services such as child care, education, welfare, probation or its remand home. Some contributions of psychiatric services to these local authority services are also a part of their contribution to the treatment of offenders in the community.

### **Psychiatric Services and the Probation Service**

87. In 1966 probation orders with a condition of psychiatric treatment were made in the cases of 235 male and 37 female offenders. 94 of these orders in respect of males, and 20 of those in respect of females stipulated that such treatment should be on an in-patient basis. Section 3(4) of the Criminal Justice (Scotland) Act 1949 provides that, when a probationer is in hospital subject to a requirement of in-patient treatment, the probation officer "shall carry out the (probation) supervision to such extent only as may be necessary for the purpose of the discharge or amendment of the order". This has however for long been recognised as too restrictive a provision. Although the psychiatric treatment of the offender takes precedence over other measures, the probation officer co-operates in various ways. These include social work with the family, influencing an offender to remain in treatment, and helping to make the necessary arrangements around the time of his discharge from hospital. Current practice appears to us to be in line with the recommendation made by the Morrison Committee on the probation service in 1962, namely that there should be the fullest collaboration between psychiatrist and probation officer, whose function should be left flexible to be adjusted according to the needs of the individual case. We note that such collaboration is not restricted to work with offenders subject to probation orders with a condition of psychiatric treatment. Other probationers may also be in need of psychiatric treatment; there are also those persons who on an "informal" basis accept the help of probation and psychiatric services.

### **Psychiatric Services and Penal Institutions**

88. We found by enquiry of physician superintendents of mental and mental deficiency hospitals, consultants in charge of psychiatric units in general hospitals, consultants in child psychiatry, and consultants specialising in forensic psychiatry that they and their colleagues contributed a total of 45 sessions per week to work in penal institutions, remand homes and approved schools in

Scotland. From other evidence received, we know that the majority of these sessions were given to work with the population of the penal establishments, and comparatively few to that with children and young persons in approved schools.

89. The penal institutions comprise prisons, borstals, young offenders institutions and detention centres, but not approved schools, which are referred to in a separate section later in this chapter. The average daily number of convicted inmates of Scottish penal institutions may, for the purposes of this section, be taken as between three and four thousand, over 95 per cent of these being male.

90. Psychiatrists can play a variety of rôles in the course of their visits to prisons and other penal establishments. Some are able to give general support to the staff and assist in the creation and maintenance of a social structure and régime suitable for the average inmate of the institutions they visit. They may on occasion be able to go further and comment helpfully on facets of prison culture such as interaction between inmates, their influence upon one another, the special significance of their leaders, and the pattern of relationships within the institution. As primary responsibility for this aspect of prison and borstal life rests with the governors of these institutions, rather than with the visiting psychiatrists or medical officers, we do not elaborate on this theme. Instead, in the following paragraphs, we focus on those inmates who by reason of their mental disorders may benefit by treatment of a specifically psychiatric nature, and the rôle of the medical practitioner in providing this. For the purposes of this chapter it is convenient to sub-divide these mental disorders into three overlapping groups.

91. The first group is characterised by clear signs of severe mental illness. A small minority of offenders suffer from such illnesses, and they are generally identified during the court processes and sent to a mental or mental deficiency hospital not a prison. Where on occasion an offender sentenced to a period in a penal institution displays such signs, the rôle of the psychiatrist may be either to treat such severe mental disorder within that setting or more probably to initiate procedures for the transfer of such an individual from penal institution to hospital.

92. The second group is what, in general medical practice, is often described as "minor" mental disorder. Offenders with these conditions are usually found at the time of their trial to be sufficiently "normal" to be sent to prison and not to hospital. During their sentence they report with complaints about their health which, if they were still living in the outside community, would lead their general practitioner to consider either referring them for specialist assessment and treatment by a psychiatrist, or (as in most such cases) to institute treatment himself. Such persons, when in a penal institution, are seen by its medical officer, who is in most instances a general practitioner undertaking part-time prison work. There are grounds for expecting that a prison or borstal population will contain a higher proportion of such individuals, i.e. those about whom a general practitioner would consider consulting a psychiatrist if his services were readily available, than are found in the general community. These grounds include the fact that the very circumstances of imprisonment will bring with them stresses which, in a susceptible individual, will precipitate anxiety or depression of varying degrees.

93. The third group is that of abnormal personality. This is found more frequently in prisoners than in the general population, and is considered in more detail later in this Report.

94. We have observed that the medical officer, when he has the help of a psychiatrist readily available, refers to that specialist a much higher proportion of the offenders under his care than he would patients on his National Health Service list. Prisoners and inmates who draw attention to their psychiatric needs by reporting sick or by behaving in an aggressive or withdrawn way are most likely to be referred. Any assessment of the demand for psychiatric services must be qualified by the remark that where the medical officer draws the line in defining mental disorder or which persons to refer to a psychiatrist depends to some extent on individual judgment and on the availability of specialist services.

### **Psychiatric Services and Approved Schools**

95. There are a total of about 1,400 boys and 200 girls in Scottish approved schools. Each approved school has its part-time medical officer, who is able to refer children with various types of illness, whether it be medical, surgical or psychiatric, to specialists in the National Health Service. In addition, some approved schools have arrangements by which they are visited by a psychiatrist, usually one whose main appointment is with the Regional Hospital Board. In most instances, however, the psychiatrist visits only on demand to see a particularly disturbed child or, if he comes on a regular basis, only at intervals of several weeks. It is the exception, and not the rule, for a Scottish approved school to have a regular weekly visit from a psychiatrist.

96. We received evidence from the staff of approved schools expressing the view that there were, amongst the populations of these schools, small yet significant numbers of children who were too disturbed to be handled in that setting. They disrupted the normal working of the school. The staff would like such children to be transferred out of the approved school, at least for a short period of treatment elsewhere, but found that little by way of an alternative service was available.

97. Uytman and McHarg (1967), from their survey of one hundred consecutive admissions to Scottish approved schools in 1961, give us a picture of the children to be found in these residential educational establishments. Their series consisted of 60 boys aged between 9 and 13½ and 40 girls between 13 and 16.

98. With reservations similar to those detailed in the previous section, where we stated difficulties in the way of arriving at the prevalence of psychiatric disorder in the prison population, we quote Uytman and McHarg's estimate of this in the 100 approved school children they studied. Four (of whom two were epileptic) were disturbed as a consequence of organic disease of the central nervous system; 17 (9 boys, 8 girls) were neurotic (pathologically anxious, dependent and love-seeking); and 7 (1 boy, 6 girls) were diagnosed as instances of behaviour disorder (i.e. gratification-seeking, impatient of delay, ill-restrained by social rules, affection for others or by punishment). These total 23 per cent of the boys and 40 per cent of the girls, i.e. 30 per cent of the whole series, the excess in the girls being due to the high proportion of them (6 out of 40) who were classified as cases of behaviour disorder in the sense defined earlier in this paragraph.

99. Connell (1965), from his experience of regularly and frequently visiting an approved school over a long period, has estimated that if giving only one 2½-hour session a fortnight to an approved school with 80-100 pupils, the psychiatrist's rôle will be limited to that of a diagnostician. He adds his opinion that if the psychiatrist can give twice this allowance of time for the same number of pupils, he may achieve close contact with members of staff on a sufficiently continuous basis for him to make use of staff relationships in modifying handling in the school, and to benefit from such relationships in his attempts to understand the realities of the school situation.

100. From the evidence we received it is apparent that there are wide variations both in the extent and nature of the psychiatric services available to approved schools and in the expectations of individual schools regarding the help psychiatrists can give them in meeting their problems. We were assured, however, by our approved school witnesses and by the Scottish Education Department that the approved schools recognised that psychiatry could with benefit play a larger part and that, if the necessary services could be provided, this benefit would extend beyond the treatment of individual pupils—regular contacts between approved school staffs and psychiatrists enabling both professions to enhance their capacity to help disturbed children.

101. Disturbed and anti-social behaviour in children and adolescents, whether or not it is occurring in the setting of an approved school, is so frequently associated with, or even a manifestation of, emotional disturbance, that this subject cannot be isolated from the question of the adequacy of psychiatric services for children in Scotland. It is in this broader frame of reference that we return to it in outlining our recommendations for the development of psychiatric services in the next chapter.

### **Out-patient services of the N.H.S.**

102. It is quite impossible for us to estimate how much provision is made for the treatment of offenders through the out-patient services coming under the administration of the Regional Hospital Boards. Obviously it is very considerable, in illustration of which we quote from the Royal Medico-Psychological Association evidence that, over a three-year period, two-thirds of the adolescent patients attending the Southern General Hospital psychiatric out-patient clinic in Glasgow were diagnosed as cases of behaviour disorder. We can take it that the youngsters in this group who had not been before a court had nevertheless been behaving in anti-social ways which had led their family doctors to fear that, unless the course of events could be interrupted by treatment, such an appearance was imminent. In other parts of Scotland also, and in child as well as adolescent psychiatric practice, a high proportion of the out-patients treated will be offenders, in that the general public would regard the manifestations of their behaviour disorders as putting them in this category, even though the courts will not have seen many of the children nor all the adolescents. We have received criticisms from the probation service that out-patient services for children and adolescents are much less adequate than those for adults.

103. To the above offenders, who are treated in the psychiatric out-patient clinics of paediatric, general or mental/mental deficiency hospitals, we add those who are seen in the Forensic Psychiatric Clinic in Glasgow—they numbered 200 individuals in 1965, three-quarters of them male, and three-quarters of them under twenty-one years of age, and made a total of 1,400 attendances.

## In-Patient Services of Mental and Mental Deficiency Hospitals and Psychiatric Departments of General Hospitals

104. Earlier in this chapter we stated that in 1966 the courts made 114 probation orders with a condition of in-patient psychiatric treatment. There would in any year be other offenders who were undergoing in-patient psychiatric treatment, on either an informal basis or detained under a Part IV order of the Mental Health (Scotland) Act 1960 (i.e. the ordinary method, not involving criminal proceedings, for the compulsory admission of mentally disordered persons). These offenders we are unable to enumerate as they cannot be separated from "non-offenders" treated under the same part of the Mental Health (Scotland) Act.

105. We are, however, able to state that, on the 31st December 1966, there were detained under the various sections of Part V of the Mental Health (Scotland) Act 1960 (i.e. the part dealing with the compulsory admission to hospital of patients concerned in criminal proceedings), the following numbers:

| <i>Type of Hospital</i>     | <i>Male</i>                                     | <i>Female</i>                                 |
|-----------------------------|-------------------------------------------------|-----------------------------------------------|
| Mental hospitals            | 227 (of whom 96 were under restriction orders)  | 46 (of whom 23 were under restriction orders) |
| Mental deficiency hospitals | 185 (of whom 8 were under restriction orders)   | 25 (of whom 3 were under restriction orders)  |
| The State Hospital          | 316 (of whom 172 were under restriction orders) | 9 (of whom 6 were under restriction orders)   |
|                             | <hr/> 728 <hr/>                                 | <hr/> 80 <hr/>                                |

The above figures, and those on admissions which follow, include patients who are awaiting trial and are committed to hospital under section 54 of the Act.

106. Of equal importance, the admissions to hospital in 1966 under Part V orders were:

| <i>Type of Hospital</i>     | <i>Male</i>                                    | <i>Female</i>                                |
|-----------------------------|------------------------------------------------|----------------------------------------------|
| Mental Hospitals            | 243 (of whom 26 were under restriction orders) | 60 (of whom 5 were under restriction orders) |
| Mental deficiency hospitals | 62 (of whom 4 were under restriction orders)   | 11 (of whom 2 were under restriction orders) |
| The State Hospital          | 30 (of whom 22 were under restriction orders)  | 2 (none under a restriction order)           |
|                             | <hr/> 335 <hr/>                                | <hr/> 73 <hr/>                               |

25 (24 of them male, and 8 of these under a restriction order) of the 376 admissions to ordinary mental and mental deficiency hospitals were transfers from the State Hospital.

107. The work of the State Hospital at Carstairs in treating the mentally ill and mentally defective (in approximately equal numbers) who require treatment under conditions of special security on account of their dangerous, violent or criminal propensities is well known. The above figures show what a big part the mental and mental deficiency hospitals other than the State Hospital also play in the treatment of offenders detained under Part V of the Act. Another statistic which illustrates this is that as many as eleven different mental hospitals, and one mental deficiency hospital, each had under treatment five or more patients who were subjects of restriction orders. We stress this because of its relevance to the argument developed in the next chapter about the optimal number of beds of "State Hospital" type for Scotland.

108. In the above figures we also quite deliberately separate patients in mental hospitals from those in mental deficiency hospitals, for not only are their needs distinct, but so also are the reactions they produce in the public. The latter are much more accepting of the idea that a criminal who is mentally ill shall on that account be treated in a mental hospital, than they are that one who is mentally defective shall be treated in a mental deficiency hospital. The mental incapacity may be apparent only to a trained observer, and so the mental defective tends to be rejected by untrained staff and the relatives of other patients.

109. Despite this difficulty, the physician superintendent of one mental deficiency hospital told us that about one hundred of his thousand patients had been in trouble with the police (though not all these had been admitted under Part V of the Act). He felt able to continue admitting such offenders in these numbers, but also whenever possible to discharge them after but short periods in hospital, for many were married and with families to support from not very high earnings in unskilled occupations. Those who came to his hospital via the courts had often been convicted on charges such as drunkenness, breach of the peace or indecent exposure. Where there was not the urgency mentioned above to return them to their families, he would keep them long enough for training in specific occupations, followed by a period of going out to work daily from the hospital before eventually trying to establish them in a new locality separated from their former criminal environment. Another physician superintendent, though having fewer mentally defective offenders in his hospital at present, expressed the view that because economic causes (including availability of sufficient numbers of simple jobs) affected the numbers of such patients referred to him, he was prepared to have to admit more such patients in the future, as industrial change reduced the numbers of suitable openings for such men and women. Yet a third physician superintendent of a mental deficiency hospital, who included amongst his patients twenty who had previously been under treatment in the State Hospital, stressed the importance of experienced staff, in sufficient numbers, in the nursing of criminal patients liable to episodes of disturbed behaviour, particularly as, since the inception of the National Health Service, the demands for hospital treatment of all kinds of mental defectives, i.e. offenders and non-offenders, had risen.

110. Dr. H. B. Craigie visited, during the duration of this Committee, twenty of the physician superintendents of mental hospitals and five of the physician superintendents of mental deficiency hospitals, to hear from them their views on the current provision in their and other hospitals for the treatment of offenders such as those who were admitted under compulsory orders after court action.

In the light of the points made in the above two paragraphs, it is understandable that in the mental deficiency hospitals he visited there was doubt about the adequacy of their staffing to meet all the problems posed by the disturbed mentally defective offender. To cope effectively with these problems, these hospitals needed a high nurse/patient ratio to permit the supervision and full occupational and recreational programme their patients require. In mental deficiency hospitals, such staffing is more important than the design or degree of security of the buildings. None of these five physician superintendents expressed the wish for a purpose-built secure unit to be erected at his own hospital; and with the possible exception of one, who regretted the necessity of having to retain any locked accommodation, they favoured continuation of the present system by which each hospital (except very small ones) makes its own provision for offenders requiring close supervision, and rejected the alternative of one hospital in each region being designated for this purpose. At the time of this survey, Dr. Craigie found between twenty and twenty-five mentally defective patients who would have been transferred from their current hospitals to continue treatment in the more secure setting of the State Hospital had the latter had vacancies for them.

111. Dr. Craigie's survey of the mental hospitals revealed that they also had about twenty-five patients who would have been transferred to the State Hospital had vacancies been available. This averaged out at a little more than one patient per hospital, with no individual hospital having more than two or three such patients. Though most of these physician superintendents wish to retain some at least of their existing locked accommodation, only a third of them thought that there was a pressing need for further provision of this kind, and these were evenly divided on whether or not it should be purpose-built. Rather, the point made by most mental hospitals was that, because their present wards are large, and they cannot afford to waste the space therein, they are obliged to keep in their locked accommodation not only those patients who require such security on medical grounds, but also many others for whom different provision would be more appropriate. There was almost complete unanimity amongst the staff of these twenty hospitals that the Regional Hospital Boards should not designate particular ones amongst them to take the offenders requiring close supervision but rather that the existing practice, by which each hospital treats those from its own catchment area, with the exception of patients admitted to the State Hospital, should be continued.

112. The State Hospital works in close co-operation with the other mental and mental deficiency hospitals referred to above. One example of this is that, over a two-year period, it "exchanged" as many as eighty patients (most of them mentally defective) with other hospitals. By such exchanges the State Hospital is able to relieve the other hospitals of their problem in coping with patients who are at a stage in their mental disorder when they require treatment under conditions of greater security than the average hospital can easily provide; and at the same time transfer patients no longer requiring to be detained under conditions of maximum security to ordinary mental and mental deficiency hospitals nearer their families and those social agencies by which they will be assisted after their eventual discharge. The value of such transfers of the latter group of patients is shown by the fact that, in the two-year period quoted, only five of the eighty had to be transferred back to the State Hospital, and only one of these for serious misbehaviour. Thus, a 75 out of 80 "success rate", at least in the

period immediately following such transfers, can be claimed for this system of exchange of patients.

113. The position of the State Hospital at Carstairs in Lanarkshire has been criticised as being too isolated, with the result that suitable medical and nursing staff are difficult to obtain. Like almost all other mental hospitals, the State Hospital has its staffing problems, but we are of the opinion that it should continue on its present site. In the first place, it is a new hospital having been fully occupied only since 1957. Secondly, because of the type of patient admitted it would be very difficult, if not impossible, to find an alternative site sufficiently near a large centre of population to have an appreciably beneficial effect on staff recruitment. Carstairs is approximately thirty miles from both Glasgow and Edinburgh, and the hospital is therefore not inconveniently placed to form part of a post-graduate programme in forensic psychiatry centred in the University of either city.

114. The State Hospital has four principal functions, namely:

- (a) To be a good hospital for the treatment of mental disorder.
- (b) To be a secure hospital.
- (c) To conduct research.
- (d) To train forensic psychiatrists, nurses and members of associated professions.

To fulfil these functions, whilst meeting the demands made by the courts for the admission of patients (and to a lesser extent the help sought by the prisons and borstals), and keeping its total numbers within bounds (a phrase whose meaning is amplified in the next chapter), the State Hospital must transfer more of its patients to other hospitals than it takes from them in return. It is only seldom that it can discharge its patients directly into the community.

115. Dr. Craigie, in the course of his discussions with these twenty-five physician superintendents, found them to be generally agreed on the need for additional accommodation for disturbed adolescents and for some form of special provision for criminal psychopaths, subjects which are taken up in other chapters of this Report.

## CHAPTER VII

### Psychiatric Services and the Treatment of Offenders— Recommended Developments

116. The evidence we received from the Royal Medico-Psychological Association includes the following passage:

“a little-developed aspect of forensic psychiatry and potentially one of the most valuable, is the help the psychiatrist can give in the rehabilitation of the offender”.

We accept this, and keep it in mind as, in this chapter, we discuss developments which will enable psychiatric services to play a more effective part in the treatment of offenders, whether they be in the community, penal institutions, approved schools or hospital.

## **Regional Hospital Boards—Psychiatrists**

117. We recommend the continuation of the practice by which the Regional Hospital Boards appoint the psychiatrists who are to be involved in the treatment of offenders. The alternative would be for the various services (such as prison and approved school) to make their own appointments. The arguments in favour of the present arrangement include:

- (a) offenders, as much as non-offenders, are members of the communities for which the Regional Hospital Boards provide specialist services;
- (b) the psychiatrist concerned will not be divorced from the main body of psychiatry. The Regional Hospital Board can provide a more varied range of duties than could any service which was providing for a particular category of offenders only. It can ensure for certain of its consultants a substantial commitment in a mental or mental deficiency hospital or clinic outside the forensic field, as well as sessions distributed between probation, prison and approved school services. This enhances the interest of the posts, attracting more applicants, and thereby enables the selection of consultants to be made from a wider field. It also enables such consultants, through their regular duties in forensic and general psychiatry, to keep abreast of advances in both branches of the subject.

118. However, it must be recognised by the Regional Hospital Boards that the present arrangement places on them a responsibility to make sure that the needs of the penal services for psychiatric assistance are fully met. In the past the provision of this psychiatric assistance has to some extent depended on the enthusiasm and willingness of the individual psychiatrist to undertake additional commitments. This is not an adequate basis for the provision of the service. Psychiatric assistance to the penal services must form an integral part of the psychiatric services of the Regional Hospital Board. We shall return to the question of staffing at the end of this chapter.

## **Probation Service**

119. We recommend that probation officers and psychiatrists should be readily available and easily accessible to one another, for general discussions as well as consultation on the treatment of any offender whom either profession considers requires their combined skills. Probation officers in certain areas are already accustomed to working with psychiatrists based on particular hospitals or clinics. Such co-operation will be facilitated by the development of the forensic psychiatric units referred to later in this Report.

## **Penal Institutions**

120. We recommend that, high though the cost would be, the resources should be made available which would enable penal institutions to become places in which rehabilitation, including that promoted by the psychiatric services, could have a proper chance of success. We see as the immediate obstacle to the psychiatrist making a much increased contribution to the rehabilitation of the offender, the fact that the latter is more often than not kept in very overcrowded, unpleasant and sometimes insanitary conditions. Thus, hundreds of men are sleeping three to a cell designed for one person, and sharing very limited

washing, working and social facilities. The persistence of this situation would seriously reduce the effectiveness of each hour of the psychiatrist's or penal worker's time received by the prison. Whilst appreciating the need for security we consider that, in penal institutions as in hospitals, a prerequisite to rehabilitation is to allow the psychiatrist to exert his influence on men and women living in an environment which is healthy, both in the ordinary hygienic sense and in the sense permitting of a wide range of activities.

121. Our first recommendation, on buildings, is followed by our second on staffing. If the psychiatrist is to play a significant part in the rehabilitation of the inmates of a penal institution, and not be confined to functioning in his rôle of diagnostician and therapist to a few disturbed inmates, he should visit the institution on a sufficiently frequent basis to be and to be accepted as a member of its team. On how frequently this should be it is impossible to generalise, because the extent of the rôle a psychiatrist sees for himself in an institution, as well as the needs of different classes of offenders for psychiatric help, both vary between wide limits—even the definition of these limits is a subject on which little research has been done.

122. From the above two main recommendations, whose implementation will affect the treatment of a wide range of inmates of penal institutions, we turn to developments which concern principally two particular types of offender who are often found in these institutions. The first is the alcoholic petty offender. Each year the Scottish courts pass 1,300 sentences of imprisonment for the offences of "Drunk and Incapable" or "Drunk and Disorderly". Half of these sentences are imposed on individuals who have been to prison on at least 6 previous occasions. We conclude that this is an ineffective way of dealing with three or four hundred men and women who repeatedly offend in these ways. During the typical sentence of 30 days or less the prison service can make little headway with the treatment of such alcoholics. We would like to see the penal services trying to have these alcoholics placed on liberation in hostels such as those run by some local authorities and certain voluntary organisations. The problem presented to society by the alcoholic offender is however just a part of that presented by alcoholism in general. This wider subject was reported on comprehensively by the Macrae Sub-Committee of the Standing Medical Advisory Committee, whose recommendations we strongly endorse.

123. The second is the "troublesome prisoner". By this term we mean the man or woman who is reacting unfavourably to those restraints which are helping fellow-prisoners to accept the discipline of their environment. Where this reaction is part of an exacerbation of acutely disturbed behaviour, the prisoner in such a state may require, for days or weeks at a time, particularly skilled management. On occasion, it may be appropriate that the more severely disturbed should be transferred to hospital for a temporary period. Good relationships and mutual confidence between the psychiatrist and the institution can facilitate the making of such temporary transfers. But skilled management within the institution may take a somewhat different form from that appropriate to his needs during the greater part of his sentence, or to those of the average prisoner. We recommend that the larger prisons should each have a small section, situated so that it may be administered as part of the institution's medical or psychiatric unit, for the temporary treatment of men or women in such a phase. A high ratio of prison officers to prisoners is required for such demanding work. These officers, through their regular dealings with such prisoners, under the guidance

of medical officer and visiting psychiatrist, would acquire additional insights which would make them all the more effective when going about their other duties. They would moreover suffer less anxiety in the process than if always having to cope with the prisoner who is "proving difficult" in the general prison setting.

### Approved Schools

124. In this section we continue to use the old term "approved school", as its meaning will be clear to all readers, whilst appreciating that under the Social Work (Scotland) Act 1968 it is intended that these establishments should become part of a general range of establishments for the care of children.

125. The child who, whilst in an approved school, is found to be suffering from a psychiatric disorder (other than that of a simple reaction to being away from home and in the disciplined setting of the school) is usually one in whom the diagnosis might have been made months or years before the final episode which precipitated committal to the school by a court. To give more children the opportunity of early diagnosis and treatment, we recommend that the Regional Hospital Boards should establish additional posts in child psychiatry on the scale advised in the McCowan Report on "Medical Services for Child Guidance", published in 1962.

126. An important part is played by the medical practitioner who visits an approved school. The evidence we received showed the value of his being able to give the school sufficient of his time to visit two or three times a week, and in addition to treating physical ailments and advising on hygiene, to take on additional functions, for example maintaining contact with other medical colleagues who had been or who might in the future be concerned with the treatment of each child. Such colleagues include the child's former family doctor and school medical officer, and the visiting psychiatrist to the school. We recommend that, when an approved school is appointing a doctor, who will usually be a general practitioner in its locality, it should enquire of applicants whether they would be prepared to help in these various ways. We recommend also that each child, on admission to an approved school, should have his name put on the National Health Service list of that school's attending general practitioner, so that he—through the ordinary Executive Council channels—would then receive the medical records (which would include previous psychiatric reports) which had been compiled by the general practitioner who had been previously attending the child and his family. Where such information is required more quickly than can be expected through Executive Council channels the general practitioner attending the approved school should communicate directly with the child's former general practitioner.

127. As with penal institutions there is a case for frequent visits by psychiatrists to approved schools. We consider one session per week a minimum requirement. Paragraphs 95–101 contain data which demonstrate this need.

128. We have carefully considered the question of the need for special facilities for children and adolescents manifesting disturbed and anti-social behaviour in approved schools. As will be expected from our general approach in Chapter II, we have rejected, as a method of tackling the question, the labelling of such persons as "mentally disordered and therefore appropriate to a hospital" or "sane and therefore appropriate to an approved school".

129. We examined the case for the building of a national unit, or regional units, reserved for the hospital treatment of "psychiatrically disturbed child and adolescent offenders". We advise against this form of development on the grounds that such a unit would be unlikely to be therapeutically effective. Congregations of such adolescents would establish their own delinquent sub-culture which would be resistant to psychiatric treatment, whether individual or group-oriented.

130. On the other hand, such difficulties could be avoided where one or two such disturbed offenders are admitted to ordinary in-patient units for children and adolescents. It is for this reason that we see the question of additional hospital provision for such disturbed offenders as part of the general question of the provision of psychiatric services for children and adolescents in Scotland.

131. It is difficult, for reasons we have already given, to make any estimate of the number of places that may be required for such disturbed offenders. Very often, although the child is "acting out", the approved school may be the best environment for him; the implementation of our recommendations for an improved psychiatric service to approved schools will improve their capacity to cope with such offenders. At other times the need may be only for a short-term temporary transfer. At best, although we see a need for some additional places for such offenders in hospital units for children and adolescents, we think that the overall need is small.

132. Our recommendation is therefore that the need can best be met by the Regional Hospital Boards establishing a series of in-patient units—which are needed on other grounds—for children and adolescents. Each might take between 12 and 25 patients. Most of the patients would be admitted following the usual route of referral by general practitioners and paediatricians; but one or two places would be available for the treatment of disturbed offenders, including those in approved schools requiring in-patient psychiatric treatment for transient disorders.

133. Finally, we draw attention to the possibility that married women, with experience in general practice or psychological medicine, might apply for part-time appointments to approved schools as attending general practitioners or psychiatrists respectively.

### **Forensic Psychiatric Units**

134. We have shown how, up to the present, psychiatrists involved in the assessment and treatment of offenders have mostly been specialists in the fields of general or child psychiatry or mental deficiency. We recommend that this should continue to be the case, but with the following important qualification. In addition to the contributions of these three types of psychiatrist, there is now a clear need for the services of a certain number of a fourth type, i.e. specialist forensic psychiatrists. Examples of the latter are of course already to be found in post, on the staffs of the State Hospital and the Forensic Psychiatric Clinic in Glasgow, and of the Eastern Regional Hospital Board. We now outline the rôle which the specialist forensic psychiatrist might have in a "Forensic Psychiatric Unit". We believe that it is the activity of this specialist, rather than the building in which the unit is based, which is the essential characteristic of this development.

135. The forensic psychiatrist has a "service" function, such as taking out-

patient clinics. These should preferably not be held in premises labelled "forensic", but rather in consulting rooms used by other specialists at different times of the week. His patients will be referred to him by a number of agencies, including general practitioners, local authority departments, the courts, approved schools and remand homes, and penal institutions. He will on occasion be consulted by other psychiatric colleagues, when they in their out-patient, in-patient or court practice need his specialised advice. He will require the assistance of colleagues in related professions such as nursing, psychology and social work, and access to beds in an already established hospital unit. His services will also be required as visiting consultant to penal institutions, and possibly to remand homes and approved schools. He will often involve his psychologist and social work colleagues in his work in institutions outwith the National Health Service. Forensic psychiatrists in the South-Eastern and Western Regions should have part-time appointments at the State Hospital.

136. A forensic psychiatrist in each region will be the focus of training in his specialty there. His post with the Regional Hospital Board should carry with it an honorary appointment as a member of the associated university's teaching staff. He will be involved not only in the training of medical undergraduates and post-graduates, but also in that of other professions concerned in work with offenders. We quote paragraph 131 of the "Report of the Royal Commission on Medical Education, 1965-68" (Todd Report) which states:

"The need for more widespread training in forensic psychiatry has been accentuated by a growing recognition that much juvenile delinquency and adult antisocial behaviour has its roots in disturbances of personality attributable in turn to adverse early experiences. The Home Office has pointed out to us that the courts and the penal system increasingly regard conviction as an opportunity to try to modify such antisocial behaviour patterns, and require the participation of psychiatrists with experience in this special field. Training in forensic psychiatry is essential for the majority of the staff of the Prison Medical Service and some experience of this type of work is a necessary part of the training of all future consultant psychiatrists. Students of forensic psychiatry require instruction in the sociological and personal correlates of criminal behaviour, in the law governing criminal responsibility, and in the various ways of dealing with offenders in whom a psychiatric disorder is suspected or demonstrated. Above all, trainee forensic psychiatrists need some first-hand experience in treating criminals. There need not be many who specialise exclusively in forensic work, but there should be at least one psychiatrist in each university centre with advanced training in this sub-specialty who can provide teaching and carry out research".

137. The forensic psychiatrist will be strategically placed to initiate, supervise and advise on research in fields in which he has a special interest. He will have a preventive rôle, e.g. in helping young people who are referred to him as at risk before they fall into the hands of the law.

138. We recommend that the North-Eastern and South-Eastern Regional Hospital Boards should each, in co-operation with its associated university, make provision for forensic psychiatry in their areas, including supporting staff and access to beds as outlined above.

## **Developments in Mental and Mental Deficiency Hospitals**

139. Dr. Craigie, in the course of the survey described in a previous chapter, found that the physician superintendents he visited showed a generally high level of interest in the treatment of those mentally disordered persons who come to them as the subjects of criminal proceedings. Such persons are invariably a small minority of the total number of patients in the hospital, and if they were not accepted for treatment by the consultant psychiatrists of their local hospitals, they would lose their present advantage of being treated within comparatively easy travelling distance of their families and representatives of those social agencies concerned in their rehabilitation after discharge from hospital. Except in Glasgow, their numbers would in any one area be too small to justify the development of in-patient facilities divorced from current hospital provision, and to move them instead to a central national unit would retard their treatment and eventual rehabilitation. Even in Glasgow, with its large population, to put a patient unnecessarily in a special unit, quite separate from other hospital provision, which became known as "for criminals" rather than for the "mentally ill or mentally defective", would be to put him in the public mind on the wrong side of a demarcation line which need not be drawn. Some of these patients can, on the grounds of their mental disorder and minor criminal behaviour, be kept under treatment in hospital for much longer periods of time than they would be kept in prison on the grounds of their criminal behaviour alone. This is to their advantage, in ensuring that they receive the treatment they need, and also best for society. It constitutes an additional reason for planning their treatment in conditions closely related to those provided for the other mentally disordered patients from the same catchment area.

140. We recommend that, where a physician superintendent of a mental or mental deficiency hospital, or a consultant in charge of a psychiatric unit in a general hospital, requests his Regional Hospital Board to develop a part of the hospital in a way which will enable it to assess and treat offenders more effectively, he should be given the fullest support. Such a request may range from the modest one of sub-dividing existing large locked wards, to permit better classification of patients into those who require to continue in such circumstances, and those who can be treated in a less secure environment, to that for a bigger development such as is described in other parts of this chapter.

## **The State Hospital at Carstairs**

141. We have given careful consideration to the question of whether the State Hospital should remain at its present size of about 350 staffed beds (3 per cent of them female), or whether it should be developed as a smaller or larger hospital. Dr. Craigie and Dr. Brittain have been able to assist us in their dual capacity of specialist witnesses and assessor and member respectively of this Committee.

142. In favour of reducing the State Hospital accommodation, it may be argued that this hospital already provides, per head of the Scottish population, more beds than do the three equivalent "Special" hospitals of Broadmoor, Rampton and Moss Side for England and Wales.

143. Against this may be put the opposing argument, namely that Dr. Craigie in his survey found about 25 patients in mental hospitals plus 25 in mental deficiency hospitals who would have been transferred to the State Hospital

had it had vacancies for them, and that this was in line with the Royal Medico-Psychological Association's opinion that there is a need for a considerable expansion of maximum security beds.

144. We agree with two additional considerations brought to our attention by Dr. Brittain, namely that:

- (a) There is an optimum size for the State Hospital, somewhere between its present numbers and an absolute maximum of 450 beds, beyond which medical, nursing and associated members of staff could not maintain their present close knowledge of each patient—this is extremely important for the high degree of security attained as well as therapy.
- (b) Because most patients in the State Hospital are visited by their families, coming from all over Scotland, it is undesirable for humane and therapeutic reasons to treat more of them in a central national facility than is strictly necessary on grounds of security.

145. We recommend that, as an immediate objective, the State Hospital should be developed to bring its total number of beds to about 400, 7 per cent of which should be for females (for the present proportion of only 3 per cent is too low), and that, provided it first secures the staff which will be necessary to treat additional patients, it might at a later date be built up to a somewhat larger size, should that prove unavoidable, but with an absolute ceiling of 450 beds. We record our support for measures which help the State Hospital in attracting medical and nursing staff, including opportunities for their attachment to universities and forensic psychiatric units.

146. We do not recommend the building of a so called "half-way house", to take patients from the State Hospital who no longer need to continue treatment under conditions of high security, yet who are not yet ready for return to the community. We consider the present arrangement, by which such a patient is transferred to the mental or mental deficiency hospital nearest his home, to be preferable, for it enables the in-patient phase in treatment to be completed in the area in which the individual is likely to settle after discharge. This facilitates subsequent out-patient treatment and after care.

### **Treatment of Offenders with Personality Disorders**

147. In Chapter II we referred to the "grey area" between the penal and psychiatric services—the area into which falls the mentally abnormal offender who may properly be the subject of either penal or psychiatric measures. We examined with special care one group of such offenders, those whose mental disorder takes the form of a disorder of personality. We did so on account of public concern about the "psychopath" and because their unresponsiveness to penal measures and to normal psychiatric measures makes this group a problem for both services.

148. In our survey we had regard to experience and practice in other countries. However, apart from the English psychiatric prison, Grendon Underwood, which is discussed in the two following paragraphs, special provision for such offenders is usually made under a code of law different to that of the penal and mental health laws of Scotland. What we learned from our survey was therefore more relevant to possible methods of treatment than to the nature of the provision to be made.

149. We visited the psychiatric prison at Grendon Underwood. The inmates of Grendon Underwood are prisoners subject to ordinary terms of imprisonment who have been medically selected from the population of longer-term prisoners in England and Wales as in need of and possibly responsive to the psychiatric régime of the prison, which, as well as giving individual treatment by psychiatrists, concentrates to a considerable degree on group therapeutic methods.

150. Grendon Underwood is clearly of major importance to British forensic psychiatry in advancing research in the psychiatric contribution to the treatment of offenders. Also, with its good buildings, freedom from overcrowding and better ratio of staff to prisoners than the average institution, it is a very good prison. We have given thought to the question whether there might be a case for the establishment of a psychiatric prison in Scotland. But it will be a number of years before data are available on which the effectiveness of Grendon Underwood can be assessed, and in the meantime we advise against duplicating this experiment in Scotland.

151. We think, however, that there is a case for experiment. The problem is not one that is likely to be capable of easy solution or solution by a single approach. There is advantage in the form of the Scottish experiment being on different lines from that adopted in England and Wales. As Grendon is a prison whose inmates are prisoners who have been initially "selected" by the criminal courts for penal measures, so it would be of value if the Scottish experimental unit were a unit of a hospital, whose inmates are patients who have been selected on medical criteria for psychiatric measures. Admission to the unit would, we think, normally be under the compulsory powers of Part IV or V of the Mental Health (Scotland) Act 1960, although there would be a place for informal admissions.

The rationale for a unit of this type lies in two hypotheses:

- (1) that the anti-social behaviour of certain offenders stems from disorders of their personalities, and
- (2) that these disorders are potentially modifiable by treatment.

We appreciate that these are matters on which many psychiatrists would be inclined to take a pessimistic view. But there is certainly a need for systematic therapeutic trials of techniques designed to modify disordered personalities; and such trials can best be carried out in a special unit devoted to the treatment of patients suffering from such disorders.

152. We would stress that we are proposing the establishment of an experimental unit and not putting forward proposals for "solving the problem of the psychopath". We may hope that in time the experience gained from such an experiment and from other work such as that at Grendon Underwood will make their contribution to the solution. We are concerned that what we are proposing should at this stage be recognised as experimental. There is a risk that the unit might come under pressure to admit patients, not on experimental criteria, but as a result of the degree of nuisance they afford to the courts and to the psychiatric and penal services. It will be important that those responsible for the experiment should have full control over the admission of patients to the unit and that they should be supported against such pressures.

153. We see the unit as providing accommodation ranging from high security to relatively open premises resembling the present "training for freedom" hostels associated with a number of prisons. It should form part of an existing

well-staffed and well-equipped mental hospital in order to have the necessary facilities available to it. Different therapeutic courses of treatment and régimes might be available within the unit; it should be encouraged to carry out controlled experiments in order to evaluate the effectiveness of the different treatments on matched groups of patients. Comparative research on the effectiveness of the experimental unit and the régimes of ordinary prisons and hospitals and of Grendon Underwood would also be of value.

154. Units of this kind can only hope to succeed if they are supported by the interest and commitment of the hospital personnel concerned, including the physician superintendent, his medical and nursing staff and the members of the board of management. They must obviously be run by psychiatrists who do not share the therapeutic pessimism of some of their colleagues about the treatment of personality disorders; but their therapeutic optimism is not in itself a sufficient justification for the establishment of such specialised units. The justification lies in their staff's ability to carry out systematic therapeutic trials in order to test the effectiveness of the treatment régimes they deploy.

### **Implications for Staffing**

155. Earlier in this chapter we have made the point that the present arrangement by which psychiatric services for the treatment of offenders are provided by psychiatrists appointed by the Regional Hospital Boards necessarily involves the provision of such services as an integral part of the Board's functions. We think it essential that, where, in future, psychiatrists are to undertake duties involving work with approved schools or the penal services, the nature and extent of these duties, for instance the number of weekly sessions, should be clearly laid down. Otherwise there is a risk that the express or implied demands of those who require the psychiatrist's services in other fields may have the effect that this work is neglected.

156. We are aware that our recommendations propose a substantial increase in the provision of psychiatric services in the forensic field. The main increase lies in the additional psychiatric time to be devoted to institutions—approved schools, prisons, borstals, detention centres and young offenders institutions. We also foresee additional demands arising from the need for the improved assessment of children under the new arrangements for the treatment of delinquents and other children in trouble. We are conscious that the staff available at present or likely to be available in the near future is inadequate to meet the demands of the additional services which we recommend should be provided.

157. We recommend, however, that the Regional Hospital Boards should, at this stage, undertake the task of planning the provision of these services. It is our impression that, at the present time, there is an element of waste in the provision of the services; that the way in which they have grown up does not provide for the most economical use of the psychiatrist's time. This, it seems to us, may have been the result of the arrangements being established on an *ad hoc* basis; only to a limited extent have the Regional Hospital Boards considered the total requirements of the institutions and services in their area and how their needs might best be met by the psychiatric resources available. We recommend that the Regional Hospital Boards should undertake such a survey.

158. With the resources immediately available being strictly limited, the Regional Hospital Boards will be obliged, in consultation with the institutions

and services concerned, to reach decisions on priorities in the provision of services—or of adequate services where some service is necessary but resources are not available to meet the full needs. We cannot make any firm recommendation on priorities; it must to a considerable extent depend on the availability of different types of psychiatric resources. But it is our general impression, so far as value in the treatment of offenders is concerned, that the most urgent need lies in the provision of psychiatric services for the younger offender and that, so far as resources are available, this is the area on which the Regional Hospital Boards could best concentrate.

## CHAPTER VIII

### Training and Research in Forensic Psychiatry

159. We take these two subjects in the same chapter, as progress in each is likely to depend on the lead given by universities and the Regional Hospital Boards. They will, however, require the collaboration of the other services mentioned in this Report.

#### Training

160. The Royal Medico-Psychological Association said in its evidence that if psychiatry was to make a really useful contribution to the administration of the law and the rehabilitation of offenders, much more attention would need to be paid to forensic psychiatry in the training of future consultants. It added that there would be many disadvantages in establishing a separate specialty of forensic psychiatry. We consider that all consultants should have some experience in forensic psychiatry, and certain of them should have a very specialised knowledge of the subject, obtained by a more prolonged and intensive training.

161. We recommend the establishment of senior academic posts in forensic psychiatry. The holders would guide the training of members of the medical and allied professions. They would be the specialists to whom other psychiatrists could turn for information and advice on forensic problems. As members of a university department they would initiate, encourage and supervise research projects.

162. We think it is for those concerned more directly with the training of psychiatrists to determine the form of training. We hope, however, that they will plan for *all* trainee psychiatrists (and not just the minority who elect to give more or less all their time to forensic work) to have better opportunities for gaining experience in forensic matters in the future. The earlier chapters in this Report have demonstrated the demand for the services of psychiatrists in various aspects of forensic work—to meet it requires a good supply of psychiatrists with an interest in and knowledge of the forensic field.

163. It is for the universities, and not for this Committee, to determine the experience required in the men appointed to senior academic posts with special responsibilities, not only in teaching and research, but also in the work of Forensic Psychiatric Units. The shortage of teachers in forensic psychiatry, which may be expected to persist for some years ahead, may well lead the universities to appoint to these posts psychiatrists who have found their own ways of gaining training and experience in the speciality (in this respect forensic

is in a similar position to child psychiatry and mental deficiency). The forensic psychiatrists of the coming decade may, however, be expected to work with their professors to bring training in this branch of psychiatry on to a more formalised basis eventually, so that by say the late 1970's an applicant for a post whose duties include being consultant in charge of a Forensic Psychiatric Unit may reasonably be expected to satisfy all the following criteria:

- (a) General post-graduate training, subsequent to passing the final examinations in medicine, of such duration as the General Medical Council shall determine at that time.
- (b) 3-year specialised training in general psychiatry.
- (c) Further more specialised training in forensic psychiatry, to include:
  - (i) ordinary out-patient work with the minor offenders, mainly young people, of the sort who attend the Forensic Psychiatric Clinic in Glasgow (the younger members of this group being treated by child psychiatrists also);
  - (ii) six months' experience in the work of penal institutions; and
  - (iii) experience in the work of hospitals such as the State Hospital at Carstairs and Broadmoor, Rampton and Moss Side.

### Research

164. We quote from three sets of evidence we received. First, by the Mental Welfare Commission,—“Adequate treatment depends on both research and training, and we urge that consideration be given to the setting up in Scotland of at least one University Department of Medical Criminology. Such a centre seems to us indispensable for the proper training of psychiatrists and others in this expanding and specialised field. A Department of Medical Criminology would be a centre for research and would co-ordinate the existing somewhat isolated services”. (Whilst our Committee is not sure that the term, “Department of Medical Criminology” is the most appropriate one, its meaning in this quotation is fairly clear).

165. From Dr. Morrice,—“I must confess that I find surprising how little formal study most universities in Scotland undertake in the subject of delinquency and its control, despite the considerable interest of the community at large. It is true that the crime problem may have to be set against its appropriate background of social cultures, community attitudes and so on. Forensic psychiatry is only one corner of the problem, but an important one, and one from which a flood of enlightenment and encouragement could spring”.

166. From Dr. Wardrop,—“From the research point of view, it should be obvious what a valuable centre a forensic psychiatric clinic (and for this our Committee would substitute forensic psychiatric *unit*) would be for the collection of material suitable for all kinds of research into delinquency. Even if no university appointments such as, for example, a statistician and/or research psychologist were to be made immediately, at least advice from appropriate university departments should be obtained as regards the keeping of records so that the material could be useful for research”.

167. During our examination of our remit we have frequently come up against the paucity of facts in forensic psychiatry. We are convinced of the necessity of research in this subject and that there are great opportunities for advances in the field. Research, including operational research, merits the strongest support.

## Summary of main conclusions and recommendations

168. We set out below a summary of our main conclusions and recommendations.

### Psychiatric Reports to the Courts

(1) *General conclusion*—After a survey of the arrangements for the involvement of psychiatrists, where appropriate, in the field of criminal proceedings, we have come to the conclusion that they are satisfactory. They are generally effective to ensure:

(i) that persons suffering from mental disorder are not the subject of inappropriate disposals; and

(ii) that courts are provided with the psychiatric reports they require.

We make, however, some recommendations for their improvement.

(2) We draw the attention of police, police surgeons and prosecutors to the procedures available for making appropriate psychiatric arrangements for mentally disordered persons at early stages of the criminal process (paragraphs 65, 66).

(3) We recommend that the Regional Hospital Boards, in preparing their lists of medical practitioners approved under section 27 of the Mental Health (Scotland) Act 1960, should provide further information regarding each practitioner in order to assist procurators fiscal and courts (paragraph 67).

(4) We do not recommend an arrangement by which requests for psychiatric reports might be routed through the Regional Hospital Boards and the selection of psychiatrist made by them (paragraph 69).

(5) It is important that procurators fiscal and courts, in seeking psychiatric reports, should provide the examining psychiatrist with full information, as available to them, about the offender and the case and the reasons for which the report is sought (paragraphs 70, 71, 75).

(6) Consideration might be given, in appropriate cases, to a longer period of remand for psychiatric reports (paragraph 72).

(7) Psychiatrists generally, but particularly child psychiatrists, find it better to make their assessments on an out-patient basis, rather than by visits to offenders in custody; courts might consider whether, in appropriate cases, they might more frequently exercise their powers to liberate on bail for psychiatric examination (paragraph 74).

(8) Courts and psychiatrists should bear in mind the possibility of the court's exercise of its power, particularly with the offender suffering from mental deficiency, to put under him the guardianship of the local authority (paragraph 76).

(9) Copies of medical reports made on offenders prior to disposal should be sent by clerks of court to the institution or service in whose care the offender is to continue, if possible on the day sentence is passed (paragraph 77).

(10) We draw attention to the anomaly by which a medical report requested by a procurator fiscal attracts a fee, yet one requested by a court does not (paragraph 78).

(11) We welcome the willingness of the probation service to provide reporting psychiatrists with social information about the offender (paragraph 80).

(12) We disapprove of the practice by which a probation officer who, whilst preparing a social enquiry report, finds evidence suggesting the desirability of a psychiatric examination, approaches a psychiatrist direct. We recommend instead that in these circumstances the probation officer should inform the court so that it may consider ordering a psychiatric examination (paragraph 81).

(13) We make detailed recommendations for the co-operation of the psychiatrist and the probation officer when both have been requested to make a report to the court (paragraph 81).

(14) Where psychiatrists have to visit and examine offenders in a penal institution or other residential establishment, the establishment should:

- (a) supply a quiet office where the assessment can proceed free of unnecessary interruption;

- (b) nominate an officer of the establishment to provide the psychiatrist with all the information about the offender available to the establishment (including any information derived from the staff's observation of him) (paragraph 82).

(15) While we are not in a position to make detailed proposals about the effect on the provision of psychiatric services of the Social Work (Scotland) Act 1968, we recognise and welcome that there will be increased demands on psychiatrists, particularly in the assessment of children (paragraph 83).

### **Psychiatric Services and the Treatment of Offenders**

(16) *General conclusion*—While we take a cautious view of the contribution which psychiatry can make to the treatment of the offender, we are satisfied that, even on this view, there is a case for the expansion of the existing psychiatric services in this field. We make recommendations to enable psychiatric services to play a more effective part in the treatment of offenders—in the community, in penal institutions, in approved schools and in hospital.

### **Regional Hospital Boards—Psychiatrists**

(17) We consider that the present arrangement by which psychiatric services for this purpose are provided by the Regional Hospital Boards should continue; we note that the arrangement necessitates the Regional Hospital Boards' accepting the function as an integral part of the psychiatric services they provide (paragraphs 117, 118).

### **The probation service**

(18) We recommend that probation officers and psychiatrists should be readily accessible one to the other, for general discussion as well as consultation on individual offenders (paragraph 119).

### **Penal institutions**

(19) The psychiatrist's potential contribution to the treatment and rehabilitation of offenders in prisons and other penal institutions is restricted by the present conditions of such institutions; we consider that the creation of a more healthy environment in such institutions, as in hospitals, is a prerequisite if the psychiatrist is to make his full contribution (paragraph 120).

(20) Penal institutions require regular visits from psychiatrists, the time available for such visits being such as to enable them to become part of the institution's team (paragraph 121).

(21) The penal services might consider, to avoid the repeated admission of alcoholics to penal institutions, the placing of such offenders in hostels (paragraph 122).

(22) A small section should be set aside in each of the larger penal institutions for the temporary psychiatric management of disturbed inmates (paragraph 123).

### **Approved schools**

(23) There is a need for the creation of additional posts in child psychiatry as recommended in the McCowan Report (paragraph 125).

(24) The attending general practitioner has an important part to play in dealing with psychiatric problems in an approved school; we recommend that this interest should be borne in mind in making appointments (paragraph 126).

(25) There is advantage in the pupils of an approved school being put on the N.H.S. list of the attending general practitioner on admission (paragraph 126).

(26) Approved schools require regular visits by psychiatrists; we consider one session per week a minimum (paragraph 127).

(27) We do not recommend the establishment of national or regional units for the treatment of disturbed child and adolescent offenders (paragraph 129).

(28) There is a case for the provision of in-patient units for children and adolescents, one or two places in each of which might be used for disturbed offenders (paragraph 132).

(29) Regard should be had to the possible availability of married women to provide general medical or psychiatric services to approved schools on a part-time basis (paragraph 133).

### **Forensic psychiatric units**

(30) Although psychiatric services in the treatment of the offender will continue to be provided mainly by specialists in the field of general or child psychiatry or mental deficiency, we consider that there is a case for the expansion of forensic psychiatry (paragraph 134).

(31) We describe the functions that might appropriately be performed by the forensic psychiatrist and the forensic psychiatric unit (paragraphs 135–137).

(32) We recommend that forensic psychiatrists in the areas of the Western and South-Eastern Regional Hospital Boards should have part-time appointments at the State Hospital, Carstairs (paragraph 135).

(33) We recommend that the North-Eastern and South-Eastern Regional Hospital Boards should take steps to make specific forensic psychiatric provision in their regions (paragraph 138).

### **Mental and mental deficiency hospitals**

(34) We recommend against the designation of a particular hospital in each hospital region for the treatment of that region's mentally disordered offenders,

and also against the establishment of a "halfway house" between the State Hospital and ordinary mental hospitals (paragraphs 139, 146).

(35) The Regional Hospital Boards should consider sympathetically proposals which some mental or mental deficiency hospitals might make to modify certain of their wards to permit the better classification of patients and treatment of those who are offenders (paragraph 140).

### **The State Hospital at Carstairs**

(36) Having set out in paragraph 112 the need for, and success of, transfers from the State Hospital to ordinary mental hospitals, we have examined the demand on, and maximum size of, the State Hospital; we recommend:

- (a) that there is a case for increasing the number of beds by 50 to 400 as an immediate objective;
- (b) that there might be a case in due course for a further expansion to 450;
- (c) that 450 should be considered the absolute ceiling for the hospital (paragraph 145).

### **Treatment of offenders with personality disorders**

(37) We recommend the establishment of a unit, as part of an already well staffed and well equipped mental hospital, for systematic therapeutic trials of techniques designed to modify the personality of offenders with personality disorders (paragraphs 151–154).

### **Medical Staffing**

(38) We attach importance, where psychiatrists are to undertake work with the penal services, to the clear definition of the nature and extent of these duties (paragraph 155).

(39) We recognise that our proposals call for a substantial increase in the provision of psychiatric services and that staff available, or likely to be available in the near future, cannot meet the demand; we recommend, however, that the Regional Hospital Boards should now make a survey in order to plan the necessary provision, and that they should discuss with the institutions and penal services concerned priorities for the deployment of existing resources (paragraphs 156, 157).

(40) We consider that the most urgent need lies in the field of psychiatric services for the younger offender (paragraph 158).

### **Training and Research**

(41) We recommend that training arrangements should be made by the responsible authorities with the object that:

- (a) all consultant psychiatrists should have some experience in forensic psychiatry;
- (b) a number should have very specialised knowledge of the subject (paragraph 160).

(42) We set out our views on the training and experience appropriate to a specialist forensic psychiatrist (paragraphs 162, 163).

(43) We recommend the establishment of senior academic posts in forensic psychiatry (paragraph 161).

(44) During our examination of our remit we have frequently come up against the paucity of facts in forensic psychiatry. We are convinced of the necessity of research in this subject and that there are great opportunities for advances in the field. Research, including operational research, merits the strongest support (paragraph 167).

169. Finally we wish to express our deep appreciation of the constant help we have received from our secretaries. Dr. Ratcliff, Mr. Simmen and Mr. Graham have taken a great deal of trouble to arrange meetings and obtain information. They have been very diligent in marshalling from all the evidence we received the essential points on which we have based our Report.

(Signed) JAMES HARPER

*Chairman*

(on behalf of the Sub-Committee)

*7th October, 1968.*

## APPENDIX A

### List of Organisations and Individuals from whom Evidence was Received

#### Organisations

(Note: The written evidence of organisations marked\* was supplemented by oral evidence).

- \*Approved Schools' Association (Scotland)
- Association of School Medical Officers and Dental Officers in Scotland
- The Council of the Sheriffs Substitute Association
- The Howard League for Penal Reform (Scottish Branch)
- The Mental Welfare Commission for Scotland
- \*National Association of Probation Officers, Scottish Branch
- \*Procurator Fiscal Society
- Royal Medico-Psychological Association (Scottish Division)
- Scottish Children's Officers' Association
- \*Scottish Education Department
- Scottish Prison Governors' Committee
- \*Scottish Prison Officers' Association
- Sheriff Clerks' Standing Advisory Committee
- Society of Medical Officers of Health (Scottish Branch)
- Visiting Committee, Polmont Borstal Institution

#### Individuals

(Note: Oral evidence is marked \*; written evidence is marked †).

- \*Dr. D. A. R. Anderson, Senior Medical Officer, H.M. Prison, Barlinnie
- \*Dr. R. Bailey, Physician Superintendent, Gogarburn Hospital, Edinburgh
- \*†Dr. W. Boyd, Consultant Psychiatrist, Prisons Service, Scottish Home and Health Department
- \*†Dr. J. Evans, Consultant in Child Psychiatry, Royal Edinburgh Hospital
- \*Miss E. I. W. Hobkirk, Governor, H.M. Prison, Greenock
- \*Dr. R. C. MacGillivray, Group Physician Superintendent, Lennox Castle Hospital, Lennox-town
- \*Dr. J. F. McHarg, Consultant Psychiatrist, Royal Dundee Liff Hospital, Dundee
- \*Mr. D. MacKenzie, Governor, H.M. Prison, Barlinnie
- \*†Dr. J. K. W. Morrice, Consultant Psychiatrist, Dingleton Hospital, Melrose
- \*Dr. H. S. Ross, Physician Superintendent, Woodlands Hospital, Cults, Aberdeenshire
- \*Dr. H. G. Smyth, Physician Superintendent, Strathmartine Hospital, Dundee
- \*Dr. F. H. Stone, Consultant in Child Psychiatry, Royal Hospital for Sick Children, Glasgow
- \*Dr. J. D. Uytman, Consultant Psychiatrist, Royal Dundee Liff Hospital, Dundee
- \*†Dr. K. R. H. Wardrop, Director, Forensic Psychiatric Clinic, Glasgow

## APPENDIX B

### Establishments Visited by Members of the Sub-Committee

Dr. Guthrie's Boys' Approved School, Edinburgh  
Dr. Guthrie's Girls' Approved School, Edinburgh  
Grendon Psychiatric Prison, Buckinghamshire  
H.M. Prison, Barlinnie  
H.M. Prison, Greenock  
H.M. Prison, Wormwood Scrubs  
Langlands Park Approved School, Port Glasgow  
State Hospital, Carstairs

## APPENDIX C

### Main Reports, Memoranda and Papers considered by the Committee

#### REPORTS

- California Medical Facility/Department of Corrections—Psychiatric Treatment Master Plan Task Force—Report of the Sub-Committee on Adult Anti-Social Reactions (1961).  
Ministry of Health—Report of Working Party on Special Hospitals (1961).  
Scottish Home and Health Department/Scottish Health Services Council—Medical Services for Child Guidance (1962).  
Home Office—Report of Working Party on the Organisation of the Prison Medical Service (1964).  
Scottish Home and Health Department/Scottish Education Department—Report of the Committee on Children and Young Persons—Scotland—(1964).  
Report by Dr. K. R. H. Wardrop on the work of the Forensic Psychiatric Clinic, Glasgow, in 1965.  
Report to the Forensic Psychiatry Sub-Committee of the Western Regional Hospital Board on the procedure for obtaining psychiatric reports for the Courts in Glasgow.  
Scottish Home and Health Department/Scottish Health Services Council—Alcoholics—Report on Health Services for their treatment and rehabilitation (1965).  
Scottish Education Department/Scottish Home and Health Department—Social Work and the Community—Proposals for reorganising local authority services in Scotland (1966).

#### MEMORANDA AND PAPERS

- Connell, Dr. P. H. "A Psychiatrist joins the staff of an Approved School", *British Journal of Criminology*, January, 1965.  
Connell, Dr. P. H. "Views on Psychiatry and Approved Schools", *British Journal of Criminology*, April, 1965.  
Forensic Psychiatry Section, Scottish Division, Royal Medico-Psychological Association. "Memorandum on the requirements for residential care of mentally disturbed adolescent delinquents".  
Jevons, M. C. "Crime and Mental Welfare", *Mental Welfare*, Autumn, 1966.  
Kloek, Professor J. "Excursion to the Psychiatric Observation Clinic, Utrecht", Ninth International Congress on Penal Law, The Hague, August, 1964.  
Philip, A. E., and McCulloch, J. W. "Use of Social Indices in Psychiatric Epidemiology", *British Journal of Preventive and Social Medicine*, Vol. 20, No. 3, July, 1966.  
Ratcliff, Dr. R. A. W. "Characteristics of those imprisoned in Scotland in 1965 on conviction for primarily alcoholic offences", *Health Bulletin*, Scottish Home and Health Department, Vol. 24, No. 3, July, 1966.  
Robinson, Dr. C. B., Patten, J. W., and Kerr, Dr. W. S., Purdysburn Hospital, Belfast. "A Psychiatric Assessment of Criminal Offenders", *Medicine, Science and the Law*, July, 1965.  
Roosenburg, Dr. A. M., W.H.O. Consultant, Medical Superintendent, Dr. van der Hoeven Kliniek, Utrecht, Netherlands. "Mental Health Aspects of the Prevention of Crime", *World Health Organisation*, 1965.  
Uytman, Dr. J. D., and McHarg, Dr. J. F. "A Psychiatric Survey of Admissions to two Scottish Approved Schools", *British Journal of Criminology*, January, 1967.

